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Community Planning for Tomorrow

TWO CURRENT articles should receive thoughtful consideration by public health nurses and by members of boards and committees for public health nursing services. One is the supplement to the Criteria of Essentiality entitled "Recommended Minimum *Wartime* Public Health Nursing Service," page 262. The other is the report of the public health nursing conference held in Cleveland in April on the topic, "Nurses Plan for the Postwar Period," page 274.

Designed to help local procurement and assignment committees appraise public health nursing service and promote better distribution of public health nurses, Recommended Minimum Wartime Public Health Nursing Service should be even more useful to public health nursing agencies in planning their work, and in correlating it with other community resources, in order that an essential public health nursing program may be maintained despite shortages in personnel and increased needs for service created by the war.

In making use of this statement it should not be forgotten that it is a pattern for minimum service designed for unusual conditions, not an ideal plan for public health nursing when these conditions no longer exist. This is true despite the fact that many areas in this country still lack even minimum services. A ratio of one public health nurse to 5,000 people might well be the immediate goal, even after the war, in areas that now have no public health nurse at all. This, however, should be only the starting point around which complete coverage may be developed.

The Cleveland conference looked forward to the reconstruction period following the war. When that time comes a minimum public health program should mean that health services for disease control, health education, and medical and nursing care during illness are available to every citizen in every part of the country.

In working toward this goal it is not necessary to know in advance exactly what part will eventually be taken by government and what by nonofficial groups. Indeed, it seems probable that in so large a country with people living under such varied conditions, no single pattern will ever be evolved. Certainly the same solution will not be found everywhere at the same time and experimentation in various methods will be valuable.

It is necessary, however, that we face the need now, and begin taking steps toward achieving the goal.

Leadership and financial assistance may be expected from federal and state health authorities. National professional organizations can provide standards and advisory service. But only by united planning in each local community can the best public health nursing program for that community be developed. Perhaps your present local nursing council for war service is a good nucleus for such a planning group; perhaps a new group must be formed. In any case it is important to start planning now.

Recommended Minimum Wartime Public Health Nursing Service*

THE RECOMMENDED Minimum *Wartime* Public Health Nursing Service outlined below is a guide to be used by Procurement and Assignment Committees in their appraisal of public health nursing service, with a view to coordinating services in order to bring about better distribution and utilization of public health nurses. It is possible of accomplishment if one public health nurse, rendering a generalized service, serves an average population of 5,000 people in either rural or urban areas where there are no unusual public health problems utilizing a large amount of nursing service, such as endemic diseases, high percentage of home deliveries requiring postpartum care, inadequate hospital facilities, et cetera.

All agencies administering public health nursing services should collectively study their programs for the purpose of working out a plan whereby a minimum wartime service can be achieved with the greatest conservation of nursing personnel. If complete generalization cannot be accomplished at once, immediate steps should be taken to coordinate nursing services. Any community having *only* public health nurses giving specialized nursing services should not be deprived of the services given by these nurses at once but steps should be taken to coordinate the special services in order to cover the minimum *wartime* program outlined below.

Generalized nursing services may be carried out in a community through the home, school, clinic, office of the agency and community groups, et cetera. The service should include health instruction and supervision and care of the sick.

I. Service in the Home

Nursing service directed to the family in the home may involve one or more of the following service categories:

A. Acute communicable disease**
   1. Visits to give or demonstrate nursing care.
   2. Visits to maintain immunization program at a protective level.
   3. Visits to implement health department regulations regarding isolation and release.
   4. Visits to carry out necessary follow-up of contact cases according to Department of Health practice.

B. Tuberculosis
   1. Visits to give or demonstrate nursing care.

*Approved by the Directing Board of the Procurement and Assignment Service, War Manpower Commission, and issued as a supplement to Criteria of Essentiality for Public Health Nurses (Nursing Information 3-C). *See* Public Health Nursing, October 1943, p. 543.

**The standards for effective health department practice in communicable disease upon which this nursing service is based are those outlined in the *Control of Communicable Diseases,* American Public Health Association, 1940.

2. Visits to infectious patients on a family service basis and to non-infectious patients with specific medical recommendations.
3. Visits to secure one examination for all contact cases and repeated visits to selected cases according to Department of Health practice.

C. Syphilis
1. Visits to infectious cases until under adequate treatment.
2. Visits to give or demonstrate nursing care.
3. Visits to those patients delinquent from treatment and who the physician believes should be followed up.
4. Visits to locate sources of infection and contact cases.

D. Maternity
1. Antepartum
   a. An initial visit to every case referred to the agency.
   b. Subsequent visits only to those patients not under continuous medical supervision with the following exceptions:
      (1) Patients presenting physical, social or economic problems or those considered hazards on account of previous maternity experience.
      (2) Primiparae in need of further instruction.
      (3) Patients to be delivered at home.
2. Delivery
   a. Nursing care during labor and at delivery should be provided whenever possible by graduate nurses not actively engaged in public health nursing.
3. Postpartum
   a. Visits preferably on first, third and eighth days following home delivery or immediately following early dismissal from hospital.
   b. Additional visits during the postpartum period only if patient's or baby's condition or home situation indicates.
   c. Visit at sixth week to interpret the need for postpartum examination.

E. Infants
1. One visit as soon after birth as possible.
2. Further visits during first year to selected cases such as: all premature infants and infants with feeding or other problems; newborn infants according to mother's and infant's needs.
3. Visits to demonstrate and give nursing care because of illness.

F. Preschool children
1. Visits only to cases with special problems, such as failure to maintain normal growth and development or difficult feeding and behavior problems.
2. Visits to demonstrate and give nursing care because of illness.

G. School age children
1. One visit to a child with special health problems which remain uncorrected, if other methods than home visits have failed, and return visits to selected cases which present physical, psychological or social problems.
2. Visits to demonstrate and give nursing care because of illness.

H. Adults
1. One visit to persons referred to nursing agencies to determine problems and give advice, and return visits only when need is urgent on basis of physical, psychological or social problems.
2. Visits to demonstrate and give nursing care because of illness.

In relation to all nursing care of the sick indicated in the above categories, it is

assumed that nursing care will be given under the direction of a physician and will be turned over to the family as soon as possible, but that continued visits may be needed where no adequate care can be arranged.

II. Service in Schools, Clinics, or Community Groups*

A. Schools
   1. Visits to schools on a planned schedule primarily for the following activities:
      Conferences with parents by appointments.
      Conferences with teachers.
      Conferences with selected pupils.
      To make or follow-up environmental survey.
      To give instruction, help plan for physical examination, first aid, et cetera.
   2. Return visits to schools for special reasons such as an outbreak of communicable disease.

B. Clinics and health conferences
   1. Public health nursing service is essential only:
      a. If teaching of patients is planned as a part of clinic procedure.
      b. If history taking is used as a device for education, interpretation, or the location of sources of infection or contact cases.
      c. If treatments under the direction of a physician are of such a nature that they should be performed by a nurse and if it has been impossible to secure personnel not actively engaged in public health nursing.

C. Community groups
   1. Group teaching should be done by public health nurses if the content of the instruction requires special skills.
      Example: Group teaching to stimulate parents to have their children immunized, or to secure correction of defects, or a class in antepartum care, might be best presented by a public health nurse. Red Cross home nursing could be taught by other nurses supplemented by assistance from the public health agency. First-aid classes could be taught by non-nurses.

III. Service "in Behalf of" Patients

Visits to interested agencies or individuals should only be made by public health nurses when the problem requires direct professional interpretation or nurse representation. Visits should not be made by public health nurses whenever the family can assume responsibility or when telephone, letter, written report, or a non-nurse substitute will suffice.

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*For service in industrial establishments, see Criteria of Essentiality for Industrial Nurses, Nursing Information 3-D. *See* Public Health Nursing, October 1943, p. 544.

Applied Democracy in Inter-Group Relationships

By WILLIAM H. KILPATRICK, PH.D.

UNLESS WE who work in health and welfare are ourselves free from prejudice and intolerance we cannot hope to work with full effectiveness. You, who work in homes, can help establish right attitudes with mothers in this inter-group tension problem; and thus you can, we hope, help in establishing right attitudes in early childhood, that most strategic of periods. The problem is difficult and the task great. Each must work as best possible.

It is from these considerations that I have been asked to discuss with you our American denial of minority rights with special reference to the factors causing it, in order that you may perhaps get fresh insight into this blot on our American social life.

Let us first get orientation from an over-all view. Lord Acton said, "The provision made in any State for the rights of minorities is the best test of the standard of civilization in that State."

Thomas Jefferson, speaking of slavery, said, "I tremble for my country when I remember that God is just."

Life in any good and full sense involves participation with others on terms of two-way communication and mutual respect. "No man liveth unto himself."

By minorities as herein considered we mean any and all sub-groups which suffer discrimination, which suffer losses in living through being shut out from the full and cordial processes of associated life.

In the treatment of our problem we can distinguish: (1) certain more fundamental factors which most cause the denial of minority rights (2) certain psychological aids or allies to strengthen the action of the fundamental causes and (3) certain hurtful ways in which these evil causes work themselves out in the community.

Before taking up these three divisions a few general preliminary remarks will help the further discussion.

While individual men differ from each other, it does not appear that races of men differ innately, either in mental ability or in emotional content or potentiality. So far as *proof* goes, the races are innately equal in ability and in disposition. The differences we see come from differences in opportunity.

These differences in opportunity mean opportunity to acquire the culture.

By the culture we mean all the ways of behaving saved up from the past by which men now live. Language, customs, institutions, morals, knowledge, standards—these tell us what the culture is and how it survives.

The individual is civilized by his appropriation of the culture. Without the culture, any one of us would be little better than ape or chimpanzee. The Indian wolf child from Midnapore well illustrates the principle:

> This girl actually taken from wolves at an estimated age of nine, could neither stand nor walk, but ran wolf-like on all fours. She could not in any wise use her hands for handling, any more than can a wolf. She lapped water like a wolf. She not only could not talk, but showed no inclination to communicate. She preferred darkness, ate carrion, feared humans,

and howled at stated intervals in the night as is the custom of wolves.

The culture keeps itself going by use. If it is used, whether good or bad, it lives through transmission to the young. This most explains our problem. Old ideas, practices now seen to be wrong, once they are built into the seamless web of the culture, hang on long after they should be dropped. Our main problem is how to get rid of now outworn ideas and indefensible practices. Parents learned them in childhood and now teach them to their children. So with superstitions; so with race prejudices.

I. *The More Fundamental Factors of the Problem*

1. The first of these factors is human exploitation, the selfish use of man by man to enrich one's own life.

Selfishness we shall see to the end of time. Here it is selfishness built into institutions that concerns us. Men have built family life on a plan to exploit women. Chiefs and nobles have exploited the common people. Masters have exploited slaves. "Haves" have exploited the "have nots." Caste, slavery, wage-slavery are historic instances. In times past not enough was produced to take care of all the people. The favored ones as masters or nobles exploited the serfs and slaves. In the case of the Negro and immigrant to this country we have this exploitation of man by man clearly at work. It gets built into custom and there it stays.

2. The second fundamental factor at work in our midst to deny rights to minority groups is the wrong use of the "we-group attitude."

A certain use of the "we" attitude is right and proper, in fact, inevitable. The child comes to say "we" of his family, but outsiders he avoids, is afraid of. But there is a bad use of the idea.

The Greeks called their outsiders barbarians and the evil they thought of these outsiders even yet defines the term barbarian for us. An early traveler in Korea saw a sign: "If you see a stranger, kill him."

It is the bad use of the "we" group attitude which helps most to constitute our problem. The family use of "we" grows into the community; but when it sees or hears about different looking and different thinking people, it often acts to shut those others out. The boundary of "we" can thus get hard and inflexible.

When the "we-group" boundary gets hardened against some people who seem not like us, it is easy to think evil of them. If one of "us" does wrong, we say "he" is a bad man. If one of the "out-group" does wrong, we say "they" are bad like that.

If there is some external sign which distinguishes these other people, as color, feature of face, peculiarity of speech or dress—any such outward sign will help unthinking people to ascribe faults to all who show this sign.

This misuse of the "we-group" is perhaps the strongest single factor at work to bring discrimination and exclusion to minority groups. Human exploitation and tribal we-group exclusion, these two walking hand in hand and working together explain the worst discriminations we have in this country.

3. The third fundamental factor to bring discrimination and intolerance we have already seen.

It is the culture working to keep alive the bad we-group attitudes and the human exploitation. The social group in which the young grow up gives to these young the group prejudices and attitudes. Thus the prejudices stay alive.

It is after human exploitation and selfish we-group attitudes are built into the culture or customs and institutions and pseudo knowledge that they take on persistent longevity. Because the evil gets thus interwoven with the good, the task of eliminating the evil becomes more difficult.

4. The fourth and last of the funda-

mental factors is the failure of people inside the we-group to understand the out-group.

For one person really to understand how another person feels there must be communication between them—two-way communication. Where we really understand, we find it hard to ill-treat. "I hate that man," said Charles Lamb. "Do you know him?" Lamb was asked. "No," he said, "I don't; if I did, I could not hate him."

Ineffective communication is the basis on which it is possible to maintain the evils of human exploitation and hurtful in-group tribalism. Take the caste system which we still maintain in a degree in this country. The master or mistress talks to the servant, giving orders as to what to do. If the orders are properly carried out, the master group mistakenly says that both understand each other. The master group has less knowledge of the servant group and how they feel than does the serving group of the master and mistress. Unless there is full and free two-way communication neither can be sure that it knows the other.

It is blind spots at this point that vitiate the thinking of most of the dominant group.

II. *Certain Psychological Allies of These Bad Factors*

We have all seen people who used their intelligence to defend what they have been believing rather than to try to find out what to think. We call this "rationalizing" and say that such people are using "defense mechanisms." Some "defense mechanisms" used by those who follow prejudice and discrimination we wish now to consider.

1. The most obvious of such defense mechanisms is a belief in "racial superiority."

The unthinking, especially within the dominant group, are sure they know about "race." They "know," they say, that the races are innately different and that their race is superior to others. We have already denied scientific justification for any such positions. The idea of "race" is very dubious and there are no known pure races. As to the superiority the argument is the other way. No differences have yet been found and best study increasingly disbelieves that any will be found. Physiological race, externally, yes; mental or emotional race, not so far as study goes.

But the matter is here introduced for another reason, to show how doctrines of "race" or "racial superiority" are "defense mechanisms" to make it easier to exploit those called inferior and to look down on them as different. If it were true that any one group were permanently and irrevocably inferior, then some kind of caste system would be easier to defend.

When I was myself in India, where caste system still holds wide sway, I found my doctrine of racial equality unwelcome to the higher classes. They wished to believe in their racial superiority.

To hold this doctrine now, the facts being what they are, is wishful thinking, the willful use of an indefensible "escape mechanism."

2. The second escape mechanism also we have seen. It is the tendency to ascribe individual shortcomings to the whole out-group.

This is again an escape mechanism to make it easy to think evil of any rejected group. And this, like the preceding escape mechanism, is again bad logic based on ignorance. Those who know the actual people recognize how bad the logic is. This bad logic, be it noted, blinds the holder while it hurts the innocent party.

3. A third psychological ally of minority baiting is the wrong use of selective attention—the tendency to see what interests us.

This is of course an originally useful trait, making for concentration of effort and efficiency. But uncritically used, selective attention deceives by failure to

note unpleasing data. A certain man, thinking uncritically, said that nowadays more men get married than women. He happened to know more of the men getting married and so concluded foolishly. A very good man I knew in my youth accepted the theological "curse" of Adam. He told me that at times he thought inanimate things behaved in a "cursed" way—falling collar buttons, for instance, preferring to roll under the bureau.

This principle helps people who wish to think evil of a group. They pick out—see quicker and dwell on—evil deeds in the group and overlook—refuse to see—their good deeds. They thus magnify the evil of the group and then (by the second mechanism discussed above) ascribe this evil to all the group. The Harlem "crime wave" seems a case in point.

4. A fourth psychological ally is rumormongering. Curiously enough, this seems much stronger among privileged groups.

When a privileged group finds its privileges threatened, it invents and spreads ugly tales about any leader they count dangerous to them. Those presidents of the United States whom privileged groups have feared have suffered the most from ill-natured rumors: Thomas Jefferson, Andrew Jackson, Grover Cleveland, Theodore Roosevelt, Woodrow Wilson, Franklin D. Roosevelt. Mrs. Roosevelt stands high in this list, especially among those uneasy lest Negroes advance.

III. *Certain Hurtful Ways in Which the Foregoing Factors Work Themselves Out*

These hurtful ways are so well known that little discussion is needed.

1. The dominant group in great degree refuses to accept certain groups as full participants in the social process. This exclusion gets into the customs and even institutions. Housing zones, quotas in schools, segregated seats in public places and public carriers are instances.

2. Political disfranchisement holds in certain parts of the country. Suffrage has been called "the right preservative of all rights" and so it in fact is. Those deprived of it are then more easily deprived of other rights.

3. Economic discrimination is again a most strategic evil. Slums, for example, breed crime. Poverty takes mothers from their homes and turns children loose on the street. Economic opportunity greatly helps but does not suffice.

4. Social discrimination defies economic sufficiency. In a way this is the most crucial discrimination of all.

5. Religious discrimination appears as a segregation in many churches.

6. Certain very hurtful agencies seem organized to exploit discriminations—to maintain and even increase them. Thus we find the Ku Klux Klan, the "Christian Front." Some of these seem the selfish tools of ulterior purposes.

A concluding word must end this presentation. The task here was analysis, to open up the problem, not to try to solve it. But it may not be out of place to suggest one important line of action.

A quotation from John Dewey states it:

> There is nothing so important in life as the free unobstructed communication of ideas and experiences, and their transmission from one to another, without any kind of restriction, censorship, or intimidation—legal, political, or extra legal.

There must be full and free two-way communication. We must think over what we learn and we must in conscience act on what we find out.

The substance of a talk given at the Twenty-fifth Anniversary Conference of the New Jersey State Bureau of Maternal and Child Health, Newark, May 2, 1944.

Public Health Nurse and Social Worker in a Venereal Disease Program

By ALICE M. KRESGE, R.N., and DOROTHY H. BRUBAKER

AS THE result of a study made during the past year at the Institute for the Control of Syphilis of the University of Pennsylvania, of the respective contributions of the public health nurse and medical social worker to the functioning of a venereal disease program, a practical division of the responsibilities of these workers has been evolved. Although future modification may be necessary, we believe this division of responsibility is sound and that it has general application because it is a logical delegation of the problems each worker is capable of handling by reason of her professional training and background.

Prior to the establishment of the Institute for the Control of Syphilis, the Clinic of Cutaneous Medicine of the Hospital of the University of Pennsylvania conducted syphilis clinics. The medical staff carried on research in the diagnosis and treatment of syphilis. The social worker developed certain techniques which proved successful in case finding and case holding. These were predicated on the philosophy of the individualization of each patient and recognition of individual problems in relation to clinic attendance and contact tracing as well as to social and emotional problems related to his diagnosis or complicated by it. During this period there was an awareness of the potential contribution of the public health nurse in the program. This was evidenced by a short term cooperative project carried on with a branch of the Visiting Nurse Society.

In 1937 the staff became the nucleus for the establishment of the Institute for the Control of Syphilis for the purpose of training personnel to aid in venereal disease control. The greatest demand was for training of public health nurses. It was necessary to give the well-qualified nurse sufficient background to act as a consultant in nursing agencies as well as to prepare the nurse working in an agency carrying on a generalized public health nursing program to integrate intelligent control of venereal disease into her whole plan of family health teaching. The emphasis in training the public health nursing group centered on case holding and case finding, and the major part of this teaching became the responsibility of the medical social worker, since she had developed this phase of the work. This led to the anomalous situation in which the medical social worker trained the public health nurse and supervised field work. It also led to confusion regarding the respective places of public health nurse and medical social worker.

This fact was recognized and a nurse was appointed to the staff to aid in supervision when field facilities were expanded. With the organization of the Division of Venereal Disease Control of the Philadelphia Department of Public Health, the teaching program was strengthened through utilization of the nursing supervisor to present that program and its relationship to community public health nursing. In 1942 the Institute appointed both a public health nurse and medical social worker to the staff with joint responsibility for service to patients and with the public health nurse directing the

teaching program for nurses. With these appointments, it was understood that a study of the professional contribution of each worker to a venereal disease program would be undertaken. A unique opportunity was offered for clarifying each one's responsibility. Because the clinic was adequately staffed with clerical and stenographic service and a separate clinic-nursing setup, both workers were permitted freedom to experiment in regard to function.

IN ADDITION to medical service, the well-organized venereal disease clinic makes provision for case holding, case finding, control of infectiousness through instruction of the patient, and, as an integral part of all of these, the education of the patient. The responsibility for these four aspects of venereal disease control does not rest solely with any one member of the clinic setup. Case holding is influenced by the atmosphere of the clinic, the convenience of hours, courtesy of personnel, the interest and concern of the doctor and his willingness to give the patient adequate time, and the proper administration of treatment to keep reactions to a minimum. Case holding is also affected by social study of the patient and recognition of what is involved for him in treatment and regular attendance. Case finding is the responsibility of the medical staff or the clinic worker to whom the responsibility is delegated. The control of infectiousness is primarily handled by prompt treatment, but the necessity for instruction of the patient in infectious precautions is obvious. The instruction is given by the physician, but is reinforced by the clinic worker who evaluates the patient's understanding of the instruction and his ability to carry it out. Education of the patient is a direct by-product of these other three factors.

Health teaching is accepted as a function of the public health nurse. Through her role as a teacher of family health, she not only aids in bringing about the recovery of the ill member of the group, but she makes a positive contribution toward the prevention of disease and the maintenance of good health. The nurse in the venereal disease clinic can contribute toward these goals. In doing so, she aids directly in case finding and case holding. This is done most effectively through the interpretative interview. During the course of this study we have come to see the interview primarily as health teaching. Health teaching is recognized to be effective in proportion to the ability to individualize the patient, but the initial interview with its concern for instruction of the patient and case finding is in the sphere of health teaching rather than social study. It is our belief that the majority of patients, following adequate opportunity for interpretation and discussion of their individual questions, are able to assume responsibility for treatment and for examination of contacts.

THE INTERPRETATIVE interview follows the physician's explanation of the diagnosis to the patient and the institution of treatment. It is a method of health teaching essentially appropriate to the nurse in her role as a teacher of family health equipped to answer the patient's questions about his own health and concerning the prevention of disease in other members of his family or among his friends. The nurse aims not only to teach the patient, but to make an educational agent of him as well, so that through his knowledge of syphilis or gonorrhea as communicable diseases other members of his group may become better informed. This interview as a teaching function of the nurse involves participation of the patient and a recognition of his feelings as does any teaching situation. With the average individual, the problems presented in the interview are concerned with health—the return to health of the patient and the prevention of the further spread of disease among members of his family or friends. During the interview, the nurse is able

to help the patient accept responsibility and to participate in arrangement for examination of others exposed to the disease. By means of the interview, the nurse hopes to educate the patient concerning his disease so that he will remain under regular treatment as long as is necessary, so contributing to case holding. She arranges for the examination of those individuals exposed to the disease, so contributing to case finding.

A procedure has been evolved in which the public health nurse interviews all patients following diagnosis for the purpose of instruction and health teaching. She refers to the medical social worker those patients who have social, emotional, or environmental complications preventing or handicapping treatment. The following examples serve to illustrate how this process is carried out.

Alfred B. was a 15-year-old boy referred by the School Medical Department. A diagnosis of primary syphilis was made. In the initial interview by the public health nurse, the boy gave contact information and seemed to have a good understanding of infectious precautions. He showed great resentment of the need for regular weekly treatment and apparently welcomed the temporary exclusion from school. The boy was referred to the social worker because regular treatment was doubtful in view of his attitude toward the referral by the school. In the course of several interviews, Alfred was able to articulate his feeling about the school and his resentment at "always being in wrong." He came to see his relationship to the clinic not in terms of something "done to" him by the school, but as a relationship necessitated by his need for treatment and as something for which he himself had to take responsibility.

Violet B. was an 18-year-old colored girl under treatment for early syphilis. Her husband was also a syphilis clinic patient. She had seen the public health nurse on several occasions following the initial interview to work out plans for change in time of clinic attendance due to working hours, and also for re-interview when she became pregnant. She came in to report to the nurse that her husband, although working, refused to give her support and that she had left him and was temporarily staying with an aunt. She said she was undecided as to whether she should take court action for herself and the expected baby, and because of these problems she was referred to the social worker. It had been explained to Violet that the social worker was the member of the clinic staff who could assist her in making a plan.

While in Alfred's case he did not see a need for the social worker's help, he was able to accept transfer without question. Violet was asking for assistance and the previous relationship with the public health nurse did not hinder transfer, but prepared her to accept the nurse's explanation of the advisability of seeking the aid of the social worker.

The clinic situation does not differ from that in which any public health nurse recognizes social problems which she is not equipped to handle herself. The process of referring first is discussed in conference with the medical social worker. Referring within the clinic should be done with the same care and thought as referring from the clinic to outside agencies. This involves not only joint thinking on the part of the nurse and the social worker, but the patient himself must see the problem in order to accept willingly the services of the social worker. These cases illustrate emotional and social factors influencing clinic attendance, and show that referrals can be accomplished satisfactorily.

Because we recognize the interpretative interview to be the responsibility of the public health nurse, since it is primarily concerned with health teaching, does not mean that we fail to appreciate the importance of social study and treatment as an aid to case holding. As already stated, every patient does not need the assistance which the social worker is prepared to give in dealing with emotional and environmental problems. Division of responsibility enables the social worker to make a more effective contribution by relieving her of the need to give the patient information about his disease, and enables her to make social treatment her primary concern.

The public health nurse in the clinic setup assumes responsibility for referring to other health agencies, transferring of patients to other clinics, and all contacts with other community health organizations. In like manner, the medical social worker assumes responsibility for all contacts with social agencies. The training

and background of each make this a logical division.

One example of the way this is carried out in the hospital is the plan for assistance to women treated for syphilis during pregnancy. After the mother is delivered, she is visited on the maternity ward by the public health nurse from the syphilis clinic. Thus, case holding is reinforced and plans made for clinic attendance of both mother and baby. Even though in the interview with the expectant mother, continued treatment following delivery and medical supervision of the baby is stressed, experience has shown that these points require emphasis. Following the visit on the ward, the clinic public health nurse sends to the visiting nurse who will give postpartum health supervision, information which will further aid the syphilis clinic in case holding. This includes the results of family investigation and needs for further examinations.

To further illustrate, the social worker assumes responsibility for contacts with all children referred by the school. This is done on the basis of our experience which indicates a need for help on the part of the child or his parents in making the adjustment to the diagnosis of syphilis and planning for treatment, as well as on the basis that the school may be considered for our purposes a social agency.

FOLLOW-UP of patients delinquent in clinic attendance is a necessary part of case holding in a venereal disease clinic. A patient is considered delinquent in clinic attendance on the basis of diagnostic category and treatment schedule. At the present time the social worker is responsible for follow-up. Each week the clerk gives the medical charts of all patients delinquent in attendance to the social worker, who decides as to the type of follow-up to be used in the case of each individual. Attempt may be made to reach the patient by telephone, letter, or home visit. At the University of Pennsylvania Hospital Syphilis Clinic there has been an unwillingness to delegate to the clerical staff first follow-up efforts by correspondence. This is based on the belief that individualization of the patient's problem is the greatest aid to successful follow-up. The evaluation as to the type of follow-up to be employed is aided by the summary of the nurse's interview which is on the medical chart. Where personal letters are used, an effort is made to have the patient feel that his problems in securing treatment are of concern, and that help is available in planning for his continued treatment.

Having considered our joint responsibility in relation to service to patients, we see its direct application to the teaching program. The teaching of public health nurses is one of the responsibilities of the public health nurse and medical social worker. Through an intensive course consisting of lectures, discussion groups, and supervised field work, the nurse is given specialized training in venereal disease control. The teaching program is carried on by the medical staff, the nurse, and the social worker. The physician gives basic medical material, including laboratory observation, demonstration of case material, legal aspects, and sessions for discussion.

The public health nurse integrates venereal disease control information from the standpoint of official and private agency into the whole field of family health, and emphasizes the specific role of the nurse in case finding and case holding, and the adaptation of medical material to nursing problems met in the field. The nursing consultant of the official agency responsible for the venereal disease control program in the community is also a member of the teaching staff.

The medical social worker presents the implications of syphilis for the patient, utilizing case material to individualize problems and to illustrate social, emotional and environmental factors influencing the patient's acceptance of medical care. Class discussion offers opportunity

for study of techniques of interviewing and for consideration of the students' own interviews. The service of various social agencies is explored in terms of resources for the patient who needs adjustment in his personal relationships, rehabilitation, relief or institutionalization.

BASED ON a conviction that a member of one professional group should not supervise members of another professional group, the public health nurse supervises all field experience. Affiliating clinics staffed with medical personnel from the Institute offer additional field facilities. The public health nurse on the Institute staff has planned conference time each week with the student during her field experience. Through the medium of these conferences, nurse and supervisor may decide that the aid of the medical social worker is indicated in order to contribute toward the solution of a problem. Appointment with the social worker is made for the student. In this way, the student receives the assistance of the social worker and the social worker contributes to the field experience of the student. This parallels the situation with which the student is already familiar in which she discusses the patient's problem with the supervisor and, when indicated, enlists the cooperation of the proper community social agency.

Whether a venereal disease clinic has been staffed with a public health nurse or medical social worker, the responsibility allocated to her has often been the same. The clinic administrator has seen a job to be done—a job which both the public health nurse and medical social worker have been willing to accept. The public health nurse emphasizes the opportunity for instruction and health teaching, the medical social worker the importance of the social component. Effective work has been done, but the medical social worker has taken on responsibilities other than practice of case work, and the public health nurse has taken on responsibilities other than health teaching. This will continue where there is but one worker, since this situation obviously necessitates a choice between public health nurse and medical social worker.

At the Institute for the Control of Syphilis, the differentiation of function has been studied. We believe that there is a place for the professional services of both workers. With both in the venereal disease clinic, the public health nurse can concern herself with service to patients by means of health teaching, and the medical social worker with service to patients by means of social study and treatment, each thereby contributing what her professional training has equipped her to do. The division of responsibility is based on principles which apply to a teaching program and which can be used in its organization.

THE AMERICAN JOURNAL OF NURSING FOR JUNE

How We Met the Poliomyelitis Epidemic, Inez L. Armstrong, R.N.

A Nursing Service Adjusts to Wartime Pressures.

Toxemia Mortality Can Be Lowered, Gordon W. Jones, M.D.

The Nurse and the Blood Donor Service, Vivian Olson Bradshaw, R.N., and Earl S. Taylor, M.D.

One Hundred Who Were Private Duty Nurses, Elizabeth Maury Dean.

Cooperating in the Employment Stabilization Program

Some Aspects of Wartime Nursing on the West Coast, Dorothy Deming, R.N.

Aero-Medical Nursing and Therapeutics, Leora B. Stroup, R.N.

A Psychiatrist's Views on "Guidance" of the Student Nurse, Charles P. Fitzpatrick, M.D.

Nurses Plan for the Postwar Period

LOOKING AHEAD to the reconstruction period, 200 nurses met in Cleveland, Ohio, April 14 and 15, for a conference on the problems and responsibilities that must be faced after the war. The meeting was called by the public health nursing faculty of Western Reserve University School of Nursing with the cooperation of the National Organization for Public Health Nursing, and the group included representatives from Ohio and five adjacent states—Indiana, Kentucky, Michigan, West Virginia, and Western Pennsylvania. Attending were directors, supervisors, and consultants of public health nursing agencies, official and nonofficial, state and local; directors of programs of public health nursing education; board members; nurses from federal agencies, the American Red Cross, and the NOPHN; health officials and members of agencies from Cleveland and adjoining counties.

The broad picture of national health problems and plans for the postwar period was outlined by Assistant Surgeon General R. C. Williams of the U. S. Public Health Service, who described some of the new problems already encountered and forecast public health goals for the future. Diseases not heretofore endemic in this country brought by returning men were discussed. The need for further research in new types of therapy, for new approaches to old, baffling problems—cancer, dental caries, virus diseases, for improved techniques in doing the ordinary job, was emphasized. Objectives for the postwar period are the extension of public health work so that essential services will be available for *all* communities; and more equitable distribution of medical care, with necessary facilities such as hospitals, clinics, and laboratories, so that people in neglected areas—especially rural and small town communities—shall be served. Admittedly, the need is acute. Difficulties in regard to method must somehow be worked out,

Greatly increased emphasis on mental hygiene was evident in all the sessions, with the dinner meeting given to a discussion of the mental hygiene aspects of rehabilitation by Dr. Luther E. Woodward, field consultant of the Division of Rehabilitation, National Committee for Mental Hygiene. Community understanding of the problems of men discharged for psychiatric reasons and better facilities for helping them are vitally important, Dr. Woodward said, with some three hundred thousand men already discharged for mental reasons and the highest single group of army rejections due to this cause—13 percent of those examined. Most of these men are not mentally ill. They have some type of emotional or nervous disability or tension that unfits them for military service. They may be excellent workers in industry. Indeed, a "mild compulsive trait," which makes for meticulous workmanship, is frequently found. Their mental attitude upon discharge is unhappy, with a feeling of failure and isolation. The public health nurse can help in the education of the family to welcome them home and encourage them to enter into normal activity, work or school, and social life. They will tend to take on the emotional tone of those about them.

Federal agencies concerned with the employment, treatment, and guidance of these men were listed. Facilities for their needs should include an efficient referral service to interview and send them at

once to the proper agency for help, thus avoiding the demoralizing "run-around"; clinic service for expert guidance of those with special problems; outpatient service from the 30 psychiatric hospitals.

The nurse's functions in the whole psychiatric program were discussed in the various sessions. She must be alert to early or recurring mental illness in her patients or families. She should participate in the community program for discharged men. And she will increasingly be called upon to help with the follow-up of patients discharged from state and veterans' hospitals. The need for better preparation of nurses in this field and of facilities for special training of mental hygiene consultants was stressed.

Broad changes and adjustments of public health nursing in the reconstruction period were discussed from the national, state, and local viewpoints, with Marion W. Sheahan, director, Division of Public Health Nursing, New York State Department of Health, as principal speaker.

The foundations for future planning were reviewed. Certain concepts and principles in regard to public health work existed before the war. Essential public health services including prevention and control of disease, health counselling and instruction, and, increasingly, care of the sick in their homes, have been accepted as a responsibility of government, with growth of federal leadership, fiscal aid, advisory help, and research, growth of state leadership to local areas with more and more financial aid, but emphasis always on local community responsibility and planning.

The war emergency threw into relief our weaknesses—the uneven and extravagant use of personnel, anachronistic programs which had not kept pace with changing needs, our failure to plan and work together nationally, within states, locally. "We're all frozen—frozen into doing certain things because we've always done them," said Miss Sheahan in stressing the importance of flexibility. New obligations brought by the war led to a broadened concept of the public health nurse's job. Introduction of new workers, nurses and nonprofessional people without public health training, necessitated a job analysis with reassignment of tasks, allocation to trained workers of activities requiring special skills, and supervision of untrained personnel. The beginnings of joint planning were forced upon us, if only to prepare for bombs which might fall. Reorientation of our whole educational program was imperative to provide nurses for immediate needs.

What of the future? The great extension of public health service envisioned requires careful planning. First, we must redefine the public health nursing program for which we expect to secure tax support, in terms of recognized standards of what comprises an adequate public health unit for a given population. Each state should then blueprint its needs for public health nursing on the basis of this definition, with numbers of nurses required at different levels according to an accepted ratio of nurses to population, for a specified period ahead.

The shifting place of the private agency in the public health picture was explored by Miss Sheahan and discussed by Emilie Sargent, director of the Visiting Nurse Association of Detroit. Miss Sheahan suggested that the private agency be redirected to the place where its greatest contribution lies, using its influence first to secure coverage of essential health services for the community, then the development of needed supplementary services, and finally coordination of the two in the best interest of the family. The importance of determining the optimal time to turn over the support of services from the private to the official agency was stressed. Miss Sargent listed some possible new objectives for a visiting nurse agency in the future—participation in a central clearance bureau for all community nursing needs, with the public health nurse perhaps in the role of initial

contact person in the family; development of a hospital-agency referral system; provision for care of the increasing case load of the chronically ill.

As a part of this planning, closer coordination with a wide variety of agencies—hospitals, teacher groups, industries, farm cooperatives, sickness insurance groups, public welfare agencies—was called for, with emphasis on the acceleration of progress toward a common goal made possible through simultaneous action of groups planning and working together. Interdepartmental coordination in state agencies, with use by one department of personnel from another, was recommended.

Greatly increased numbers of nurses for both public health and clinical work will be required to staff expanded public health and medical care programs. The U. S. Nurse Cadet Corps is one source for the future. The war has taught us more efficient use of personnel. One suggestion for stretching nurse power, made by Pearl McIver, principal nursing consultant, U. S. Public Health Service, was the use in an area of a team of nurses, one with public health training and one without, the latter as assistant under supervision of the former.

Extension of opportunities for public health nursing education is an important concomitant of all these plans for the future. Many aspects were discussed: (1) further development of integration of health in the basic curriculum, with interchange of instructors between agency and hospital (2) use of graduates from schools with high standards for first level public health nursing positions, without further preparation (3) adaptation of postgraduate courses to the needs of graduates from modern schools and further adjustment of field work to individual needs and experience (4) programs on an in-service or university basis to prepare new supervisors, essential in a plan for using less highly trained personnel (5) in-service program for state directors of nursing, suggested as an activity of the U.S. Public Health Service (6) development of opportunities for preparation in the clinical specialties adapted to the needs of consultants in these fields. The patchwork character of preparation available for consultants was brought out by Ruth Taylor, director of Nursing Unit, U. S. Children's Bureau.

Several specific problems of the reconstruction period received attention. Reestablishment of health services in all nations whose health work has been destroyed by the war will be a task which our government must share. Adjustment and retraining of returning military personnel, including nurses, will be a government responsibility. This program should be administered by existing federal agencies with acceptance of professional standards and a related plan for jobs for trainees. The danger to standards from veterans' preference laws must be watched.

That the core of a successful health program is always effective health education was emphasized in conclusion. Any successful program must be applied to and accepted by the family. This is true regardless of the responsibility which government assumes. Likewise, lay participation and community understanding are the basis for any enduring community program. We may *think* ahead of the community, but how far we can make it *go* depends ultimately on our skill in health education. This fundamental principle must be kept in mind in all our planning for the future.

Records and Reports

By MRS. NAN A. COX HARE, R.N.

FROM PREHISTORIC days up to now, there have been all kinds of records, some made intentionally, some made unwittingly. Of the latter, some of the best examples are footprints. On the mountainside near Berea, Kentucky, footprints in stone were discovered a few years ago. When I visited the spot, I could see five distinct footprints. They were of some human form and had been made thousands of years ago. No one knows when—not even the wisest archaeologist—but they were a record of a living human form. They had been made in soft sand or molten material and then covered over by a flow of other molten material. It has taken hundreds of years for nature to dissolve and wash away the upper layers of stone and leave the footprints there. Someday something else may come to light that, put with the footprints, may make a more complete story.

Then we have crude pictures and scrawls on the walls of caves and cliffs. I saw some such on the cliffs by a waterfall in the center of the Island of St. John, one of our Virgin Islands. We have pieced together the story of those crude drawings and know they were made by the Caribs. From crude drawings, we come into the period of human writing and recording. We have built on the records of the past; the future will build on our records.

Nature in all forms leaves records. The skeletons of man and beast tell of their form, the structure of their teeth, even of their industry. Some ten years ago the skeleton of a man was found pinned under a rock in Mammoth Cave. There was a good record found with him—clothing and sandals made of woven bark, a crude instrument. He had been digging for gypsum. A gourd of sunflower seeds for food was found by his side. His was an industrial record.

We saw a tree down and count the rings for the number of years of growth—a record of age. We pick up fossils from the earth and tell what manner of animal life was once there.

Thousands of people are busy daily making records—sketching, painting, sculpturing, photographing, sound recording, and writing—making records. In our own field, for example, we can hear Florence Nightingale's voice on a record.

We believe that records are important in all walks of life. We believe it to the extent that men risk their lives to make records. We have a photograph as a record of the crashing of the plane which sent Raymond Clapper to his untimely death—he, who was making a written record of our war activities. And so it goes.

I believe records are important very important to the industrial nurse. We are only 50 years on our way in industrial nursing. We have been accomplishing some things in those 50 years. We have shown by our records of those accomplishments that we were rendering a worthwhile service; otherwise, industry would not have continued the use of industrial medicine and nursing. Now it is up to us to take those records and build better records for the future if we are to maintain our place in serving industry and the industrial worker.

It has been very aptly stated that records and reports are to the industrial nurse what bookkeeping is to the accountant. Through good records, she can demonstrate to Management and Labor the desirability and value derived from having a medical service.

The Committee to Study the Duties of Nurses in Industry and the Advisory Group of that Committee recommend that the following types of records and reports are needed:

1. Individual records, including the medical examination, clinical visits, and the correction of remediable conditions
2. Daily record or log
3. Disability absentee records
4. Compensation records and reports
5. Monthly and annual reports to management

I shall discuss briefly these records beginning with the first named:

1. *Individual records including medical examination, clinical visits, and correction of remediable conditions.* All good records are based on an accurate history of the worker and a careful physical examination by a physician. Dr. William J. Fulton has very aptly stated that "the pre-employment physical examination is branded as the 'cornerstone' of industrial health. Insofar as being an initial guide to proper placement in relation to physical qualification, it is the 'cornerstone.'" If it is at all feasible for the nurse to take the history, she is the one who should do it. This gives her an opportunity to get acquainted with the worker and to allay his fears about his physical examination. She may even do more than take the history; she may participate in the physical examination by making vision and hearing acuity tests, taking specimens for serological and other laboratory tests, making blood pressure readings, and with the women workers will chaperon for the doctor. Following the physical examination, whether the nurse has assisted or taken the history, she should go over the physical findings with the worker and interpret their meaning to him if the doctor has not done so. This offers the nurse an excellent opportunity to begin her health teaching, as many of the records will show obvious rehabilitation needs and lack of proper immunization.

Once these records have been made, they should be kept strictly confidential except as interpretations are needed for management to adjust the worker to his job. This assurance should be given the worker when the physical findings are reviewed.

Building up a clinical record can be a very fascinating story—the nurse adding line by line to make whole chapters, such as chapters on vaccination, typhoid immunization, teeth repair, eyes corrected, better adjustment to working environment, and often adjustments to home and community environment. The record of the industrial worker can reflect the whole story of a man's life in relation to his family, community, and industry. Any nurse with imagination and interest can make a record as a tree showing where the roots sink back into the past for strength or weakness, how the trunk has been damaged or has escaped damage as the case may be, and how the branches reach out into daily life, the work life, the home life, the social life, and the spiritual life. It may become a nurse's high privilege to assist the worker in all these phases of living and only a carefully made record can guide her in this.

2. *The daily record or log* helps the nurse to evaluate her service and to give an account of her stewardship. If she is a thoughtful person, she will analyze her day's work in terms of human relationships and not in terms of mere activity or "busyness."

How well I remember an experience I had a few years ago when I spent the day with a public health nurse on the West Coast. She would break off her work during a treatment or conversation to chase over to her desk and record an activity. The activity may have been a telephone conversation she had had pre-

viously or some part of the business at hand. The whole emphasis was on getting in so many activities by 4:30 p.m. She felt that her success as a nurse depended on getting a large number of activities to report. In the last two years her town has grown from a population of 27,000 to 137,000. She probably is not worrying so much about the number of activities now, but I worry about what a nurse so bound by routine is able to give her people.

3. *Disability absentee records* show what happened when the machinery broke down. These records may show that the steel chain broke or that the girder slipped or that there was a weakness in the conveyor belt; but they may also show that the worker did not wear his goggles; or that he came to work too worried about home conditions, didn't think clearly, and got in the way of a machine; or that he neglected his cold and was home with pneumonia; or maybe that he quarreled with his wife and got drunk, and they pulled him out of the ditch from under the car in too many pieces. Unfortunately, records write the story of tragedies, some of which could have been avoided. The wise nurse will take these records, use them, and show both worker and industry how to eliminate similar tragedies and other unfortunate happenings in the future.

4. *Compensation records and reports.* Those are the records and reports that tell industry where and why the man was injured on the job. They tend to point out the faults of industry; namely, placing a man in a position where he is not equipped to do the assignment without injury to himself or others, poor leadership and supervision, or faulty machinery. This is probably the most difficult record and report that the nurse has to make. By virtue of her employment, she represents management, and by her professional interest she represents the worker. It is here that she has to do the most careful interpreting. While she is not the judge as to the extent of the injury (the doctor carries that responsibility), she is often the first person to record information about it,and in doing so must be very careful about every detail, no matter how small and no matter how slightly related to the injury it may seem. And *always* in such reporting she must be as neutral as Switzerland and as helpful as St. Christopher.

5. *Monthly and annual reports to management.* These give the nurse her trump card. It is here she can tell her story not only in figures and graphs but in well chosen words. She can report her achievements and defeats. It is here that she can give management a picture of activities and conditions in the plant that are affecting the health and welfare of the workers. And in addition to reporting problems she needs help in solving, she should always try to find something good to report; and if she tries hard enough, she always can. It is here that she can tell how the cafeteria, the restrooms, the lighting, and the general sanitation affect the worker. She can write in terms of how all of the above is reflected in good or poor production. The healthy, happy, satisfied worker is the good producer. The report should be short, direct and interesting. The nurse should welcome an opportunity to write a report.

I once knew a professor of physical education who, when he was asked if he knew something about a subject, would always reply, "Yes, I have brushed on that." Like him, I have only brushed on the subject of records and reports, but I am listing a reference which offers many helpful suggestions in organizing the nurse's record system. It is: "Records—the 'Seeing Eye' of Industrial Medicine" by William J. Fulton in *Industrial Medicine,* January 1944, p. 1.

Paper given at First Annual Conference of Industrial Nurses of Mississippi, Jackson, March 17, 1944.

Public Health Nursing Program and Functions*

IN PREPARING for community health services for the period of demobilization and full return to peace, the re-evaluation of public health nursing functions is basic to any consideration of future program.

After several years of wartime modifications in public health nursing—some purely expedient to be discarded as soon as possible and others with constructive implications for the future—a restatement of guiding principles now seems appropriate.

Public Health Nursing Defined

For purposes of this statement, a public health nurse is a graduate registered nurse having special preparation in public health nursing as outlined in the NOPHN Recommended Qualifications for Public Health Nursing Personnel, 1940-1945.**

Public health nursing is an organized community resource for furthering public health measures designed to prevent and reduce sickness and to produce positive health. These measures include environmental planning for health and safety; opportunities for gaining knowledge and attitudes favorable to maintenance of health; facilities for diagnosis and for preventive and restorative treatment. The contribution of the public health nurse is essentially educational, whether her service is given in the form of nursing care to the sick or health guidance and instruction to the sick and well; whether she works in home, health center, clinic, school, or industrial plant; whether she is employed by a governmental or voluntary, health or non-health agency. Her services are available to all age groups in all economic and social circumstances—to those who can afford to pay full or partial fees as well as to those who cannot.

Broadly speaking, then, the functions of public health nurses are to help make known scientific facts about health; to help create positive attitudes toward the acquisition and maintenance of health; to encourage and teach the use of health and medical resources; to contribute toward the adjustment of social conditions to the end that the individual and the family will become resourceful in meeting their health needs. The public health nurse has a community responsibility in keeping before the attention of its citizens the needs and reasons for adequate funds, facilities, and services; in helping the community to understand and apply efficient, economical methods of administering and coordinating nursing services in order to obtain maximum benefits without duplications and inequalities.

Public Health Nursing Program

Although many types of service are embodied in a public health nursing program, each requiring some differentiation in approach and content, this is entirely compatible

* Approved by the Committee on Nursing Administration of the National Organization for Public Health Nursing.

** Public Health Nursing, January 1942, p. 24. Reprints available.

with a generalized service whereby every public health nurse serving families directly gives all the kinds of public health nursing they need.

Public Health Nursing Functions

Essential to good quality in any public health nursing service are awareness and understanding on the part of the public health nurse of:

The total health and social movement to which she contributes.

The bearing of economic and social factors on individual and national health.

The motivations and individual variations in human behavior and their significance in the preservation and attainment of health.

Principles of mental hygiene and their application, for making nurse-patient and worker-to-worker relationships more productive for all concerned.

The relation of nutrition to health and to normal growth and development, including signs of poor nutrition.

The significance of adequate recording and reporting of conditions and services in continuity and completeness of care, in evaluating past and planning future activities; and in relating needs to program.

Functions applicable to all phases of a generalized public health nursing service are:

Studying health needs in relation to the physical and mental condition of the individual, his family situation, and his working environment.

Encouraging and helping to secure continuous health supervision.

Bringing people not receiving medical supervision or care when needed into touch with available resources.

Helping the individual plan his daily life in a way to enable him to make the most of medical advice and all other health services at his disposal.

Giving and arranging for home nursing when needed for all age groups and health conditions.

Teaching others to give this care—relatives, non-nurse helpers, midwives—under professional nursing supervision.

Aiding in the development of community resources for health education and for prevention and treatment of illness by contributing to general knowledge of needs and by sharing in community planning and action.

Differences in various phases of the public health nursing program grow out of the actual needs of each age group or health condition, not the availability of special funds or special agency interests, and do not imply specialized workers. They are reflected in the activities of the general public health nurse, as follows:

MATERNITY

Getting in touch with prospective mothers and assisting in securing medical and dental examination and supervision early in pregnancy and throughout the maternity cycle.

Assisting in planning and preparing for hospital or home confinement.

Helping to secure postpartum medical examination.

Giving or arranging for nursing care at delivery if at home, and for the postpartum period.

Teaching others by demonstration, and supervising care given by relatives, attendants, and midwives.

Helping the family to carry out specific medical advice for the mother's and baby's care.

Helping the family, if eligible, to utilize special provisions for maternal care such as those available through federal and state government.

CHILD HEALTH SUPERVISION

The infant and preschool child

Assisting in securing complete birth registration.

Assisting in securing medical supervision, dental examination and correction of defects for every child.

Giving or arranging for nursing care of sick children, teaching through demonstration, and supervising care given by relatives and attendants.

Assisting in the control of communicable diseases through teaching the recognition of early symptoms, the importance of isolation and the value of immunization.

Participating in programs for the prevention of handicaps and the care and education of handicapped children.

Assisting the family to carry out general and specific medical advice concerning feeding, with emphasis on breast feeding.

Assisting the family to carry out general and specific medical instruction concerning early child care and training.

The school child

Participating in developing school health education programs based on the needs of the pupils.

Assisting physicians in the examination of school children and interpreting findings and recommendations to teachers, parents, and children.

Teaching the value of adequate health supervision and helping in the use of health facilities.

Assisting in securing correction of defects.

Instructing teachers, parents, and pupils to observe and recognize normal health and deviations from it.

Assisting in the control of communicable disease through teaching the recognition of early symptoms, the importance of isolation, and the value of immunization.

Promoting the maintenance of a physically healthful school environment, including sanitation, seating, lighting, ventilation, school lunches and other physical factors.

Promoting the maintenance of an emotionally and socially healthful school environment.

Arranging for the care of emergency and minor injuries and illnesses in accordance with medical standing orders.

Participating in a program for the prevention of handicaps and the care and education of handicapped children.

Coordinating public health nursing activities for school children with all other health forces of school, home, and community.

Participating in curriculum making, and giving group instruction in principles of healthful living and home care of the sick.*

ADULT HEALTH SUPERVISION

Encouraging periodic health examinations.

Teaching the fundamentals of personal hygiene in order to assist in the prevention and retardation of diseases specific to adult life.

Assisting in securing early diagnosis and treatment of those diseases.

INDUSTRIAL NURSING

Promoting positive health through teaching individuals and groups of workers personal hygiene and the prevention of disease and injuries.

Giving or providing for first aid under medical direction, and also for necessary subsequent care to sick or injured employees.

Assisting the physician with medical examination of employees.

Assisting in securing the correction of defects.

Coordinating the health service with the industrial relations program, which may include:

- Assisting the safety department in the interpretation of its program.
- Keeping adequate medical and health records of all cases including compensation cases.
- Offering consultation service to the manager of the lunchroom.
- Interpreting the plant sanitation program to employees.
- Assisting in developing recreational facilities.
- Making available to various departments appropriate data from nursing records.

Coordinating the nursing service with the other health and social services in the community through:

- Securing needed health and social service for the industrial worker and his family.
- Developing working relations with the health department and other community agencies and securing their participation in promoting health within the plant.

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* This requires qualifications in the field of education as well as public health nursing.

PROGRAM AND FUNCTIONS

COMMUNICABLE DISEASE CONTROL

Acute communicable diseases

Promoting the complete reporting of reportable diseases.

Teaching the need of medical care and assisting the family to secure it.

Giving or arranging for home nursing care, teaching through demonstration, and supervising care given by relatives and attendants.

Assisting the family to carry out isolation technique and general and specific medical instructions.

Interpreting health department procedure to individuals and groups.

Assisting, under authority of the health department, in making epidemiological investigations.

Instructing parents, teachers, and other individuals and groups:

To recognize early symptoms and isolate suspected cases.

To carry out proper precautions to prevent the spread of infection.

To provide adequate convalescent care.

Helping to secure specific immunization.

Tuberculosis

Assisting in securing reporting of all cases.

Assisting in finding cases, especially those with early minimal lesions and their contacts, and securing medical examination and supervision.

Securing medical examination and supervision for all cases and contacts.

Assisting, under authority of the health department, in making epidemiological studies, and where feasible, in installing central case registries.

Helping to arrange for sanatorium and post-sanatorium care.

Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and attendants where sanatorium care is not available or is refused by the patient.

Using state and local facilities for rehabilitation of the patient.

Teaching patient and family the importance of personal hygiene and the precautions to be taken to prevent the spread of infection.

Stressing the importance of early diagnosis and X-ray examination.

Interpreting the significance of the tuberculin test.

Helping patient and family with emotional and social adjustment to a long-term communicable disease.

Helping to inform the community regarding prevention, control, and treatment of tuberculosis.

Assisting in integrating services of clinics, sanatoria, private physicians, health department, and other related health and social agencies.

Venereal diseases

Assisting in finding cases and contacts and in securing medical examination and supervision.

Promoting continuity of treatment by helping the patient follow medical directions, and cooperating with other workers to this end.

Teaching patient and family the precautions to be taken to prevent the spread of infection.

Teaching scientific facts concerning these diseases to individuals and groups.

Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and non-nurse helpers.

Assisting, under authority of the health department, in making epidemiological investigations.

Promoting the reporting of cases.

NON-COMMUNICABLE DISEASE

Assisting in securing early medical diagnosis and treatment.

Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and attendants.

Assisting in arranging for and giving special care to patients with special types of disability such as orthopedic, arthritic, and cardiac conditions, diabetes, and cancer.

Assisting in planning convalescent care and rehabilitation of the patient.

Observing and assisting in adjustment of health situations in the homes of patients; teaching general hygiene and the prevention of disease; and bringing the family in touch with appropriate community health resources.

ORTHOPEDIC SERVICE*

Assisting in finding orthopedic cases.

Observing and helping others to recognize and eliminate environmental conditions or habits which might produce postural or other orthopedic defects.

Observing and helping eliminate conditions of bed patients which may cause contractures, foot drop, or spinal curvature.

Observing and teaching others to recognize orthopedic defects and helping to secure medical diagnosis and supervision.

Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and non-nurse helpers.

Giving or securing skilled physical therapy under medical direction to prevent deformities and secure maximum return of power to muscles and joints.**

Teaching patient and family the importance of self-reliance on the part of the crippled person, promoted by encouraging independence in daily activities and interest in useful occupations.

In addition to the activities related to various phases of a general public health nursing service as enumerated above, the public health nurse also contributes to public health measures in the fields of sanitation and vital statistics.

In the field of sanitation, her assistance may include:

Ascertaining the source of water supply and the means of excreta disposal in homes and schools she visits, and referring them to the public health engineer for investigation when necessary.

Teaching the importance of correcting unsatisfactory sanitary conditions, and the methods of immediate protection pending their correction.

Observing ventilation and screening and teaching proper measures in relation to them.

Inquiring about the source of the milk supply, and teaching standard sanitary methods of milk production and handling, including pasteurization.

In the field of vital statistics:

Instructing as to the value of birth registration and the importance of accurate statements on birth certificates, and making sure that births are registered before closing maternity cases.

Cooperating with the registrar in reporting names of newborn babies known to her in localities where birth reporting is poor.

Reporting stillbirths or deaths of shortlived infants who may be buried without formalities.

Assisting with morbidity and mortality studies which are useful in determining needs for service and in formulating public health programs.

Medical Approval of Standing Orders

Medical approval for specific nursing procedures in the care of the sick and for general preventive and instructive services is basic to public health nursing practice. This approval is usually obtained in the form of standing orders endorsed by a medical group designated by the agency administering the public health nursing service. In case of nursing care of the sick, medical directions also come directly to the public health nurse from the patient's physician. Standing orders are used until special orders can be obtained and/or unless special orders are not given.

Citizens' Committee

Guidance from a citizens' or consumers' committee is essential to the best development of a community public health nursing service whether under official, nonofficial, or joint administration.

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* This service is discussed separately because of the special attention given to crippled children's services through federal and state appropriations.

** Public health nurses give this treatment only if they are also qualified physical therapy technicians.

Students Study the Curriculum

By AUDREY HOLT, R.N., and CAROLINE A. ROSENWALD, R.N.

AT THE University of Minnesota students have, for the past two years, participated actively in the evaluation and revision of the public health nursing curriculum. This activity has been carried on by the Public Health Nurses' Club, through its Education Committee. This Committee is elected by the members of the Club and its functions are:

1. To interpret student opinion to the faculty and proper administrative officers of the University
2. To provide a channel through which students may express approval or disapproval of various aspects of the program, or make suggestions for change
3. To represent the student body on the Advisory Committee of the Public Health Nursing Course

Because of its interpretive capacity and recognized place in the planning group of the Public Health Nursing Course, it is in a particularly advantageous position to contribute constructively to studies of the curriculum. The recommendations of the Committee have already resulted in several changes in course content and in projected plans for the future.

During the academic year 1942-43, the faculty undertook a study of the academic content of the curriculum. The Education Committee decided that they might be helpful in securing the reaction of former students now actively engaged in public health nursing, and soliciting their suggestions for change. A questionnaire was devised with the help of the head of the division of biostatistics of the department, and sent to students who had completed their university work within the five years, 1937-42. Information was secured on: (1) amount of theoretical work completed (2) public health experience before and after theoretical work (3) whether certain specified courses were very helpful, moderately helpful, or of little value (4) evidences of course requirements or content which were repetitious, impractical, poorly adjusted to the level of the student (5) specific recommendations for expansion, changes in course requirements or content.

The Committee encouraged a frank appraisal of courses by including in the letter of directions a statement which assured the student that her response would be considered confidential by the Committee and would in no case be presented to the faculty as an individual report. The replies gave evidence of careful thought and included many constructive suggestions. These were tabulated, analyzed, and presented to the faculty in the form of a report with specific suggestions relating to the revision of the curriculum. The head of the Department of Preventive Medicine and Public Health and the director of the course in Public Health Nursing took the responsibility of interpreting these findings to the various members of the teaching staff. Action taken by the faculty as a direct result of this study includes:

1. Several courses were analyzed carefully to eliminate repetition in content
2. Lecture, recitation and written work in one class were reviewed and reorgan-

ized in order to promote better correlation

3. One course was completely revised to bring it into line with job requirements

4. Recommended that consideration be given to the organization of a class in geriatrics, and one in office management

5. Incorporated into individual student counseling the fact that certain courses were particularly valuable to those in the field (written English, speech, elements of preventive medicine, principles of public health nursing, group teaching, and supervision)

6. Arranged a conference with each instructor whose course was studied to interpret student reaction

During the school year 1943-44, the Committee has begun a study to determine the opinion of students as to the value of field experience. The faculty and some of the graduate students are also studying other facets of the same problem. A questionnaire was again selected as the method of securing information on the reaction of those who have had field work in urban, rural and school situations within the past 18 months. The data will be assembled and presented to the faculty in the same manner as in the previous report. It is expected that this student opinion, as well as the faculty study, will determine future policies relating to student field experience.

Members of the faculty have expressed to the group their appreciation for this fund of new ideas which will provide a basis for specific and constructive administrative action. The student body, too, derive considerable satisfaction from the realization that they have had a part in the planning of their own program. This democratic spirit on the part of both students and faculty has done much to foster the friendly relationships which exist between these two groups.

NURSE PLACEMENT SERVICE

NPS announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Lydia Arndt, generalized supervisor, Toledo District Nurse Association, Toledo, Ohio.

*Winifred Cole, supervisor, The Visiting Nurse Association, Harrisburg, Pa.

Mrs. Nell N. Stewart, tuberculosis clinic supervisor, Visiting Nurse Association, Dayton, Ohio.

*Mrs. Jean Renault, director student health service, Eastern Maine General Hospital, Bangor, Me.

Virginia Knott, public health nurse, County of Riverside, Riverside, Calif.

*Mrs. Hazel Scott, public health nurse, Visiting Nurse Association, Spring Grove, Pa.

Bobbie Lee Howell, staff nurse, Visiting Nurse Association, Detroit, Mich.

Mrs. Madeleine G. Dryden, industrial nurse, Link Belt Company, Chicago, Ill.

Levonarda E. Grybok, industrial nurse, American Car and Foundry Company, Chicago, Ill.

Lorene E. Nafziger, camp nurse, Camp Algonquin, Algonquin, Ill.

Fern Marion Swanke, camp nurse, Camp Oak Openings, Saugatuck, Mich.

Nancy A. Tardi, camp nurse, Camp Henry Horner, Round Lake, Ill.

ASSISTED PLACEMENTS

*Grace Beers, supervisor, Public Health Nursing Association, Pittsburgh, Pa.

Jewell Amel, industrial nurse, U. S. Signal Corp Depot, Chicago, Ill.

*Mary I. McCarthy, director of nursing services, American Red Cross—Cambridge Chapter, Cambridge, Mass.

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*The NOPHN files show that this nurse is a member.

Public Health Nursing Services in Clinics

By HORTENSE HILBERT

4. Public Health Nursing Time in Clinics

Information of two kinds was obtained in regard to public health nursing time spent in clinics: first, through studies and estimates by the administering agencies; second, through observations by the surveyors of time spent.

TIME STUDIES AND ESTIMATES

Time studies and estimates were made by administering agencies in 167 of the 212 clinics surveyed. In 13 of these, or about 8 percent, public health nurses devoted full time to clinic service. In 42, about 25 percent, public health nurses devoted less than 10 percent of their time to this service. Between these two extremes of 100 percent and less than 10 percent the remaining 112 clinics showed wide variations.

The median proportion of public health nursing time in clinics based on time studies and estimates was 22 percent.

ACCORDING TO SURVEYORS' OBSERVATIONS

The amounts of public health nursing time spent in the clinics as recorded by surveyors during their period of observation are shown in Tables IV, V, and VI.

Before the Clinic. The highest amount of public health nursing time spent in preparation, as shown in Table IV, was 16 hours in 2 crippled children's clinics in 2 different states, although one other schedule for a crippled children's clinic held twice a year showed that 2 public health nurses were active in planning for the clinic for a week preceding the clinic session. Both of these were administered by non-public health agencies—1 a state crippled children's commission, the other a state department of welfare. The 16 hours of public health nursing time were given by 1 public health nurse in 1 clinic and by 2 in the other, 1 conducted once and the other twice a year.

The lowest amount of public health nursing time reported for clinic preparation was 10 minutes, in a child health conference administered by a county health department, and in 3 venereal disease clinics—1 administered by a county, 2 by state health departments. In the former, sessions were conducted each month, and 7 was the average number of visits to the clinic reported. On the day visited, the attendance was 5 and the only personnel at work before the clinic session were 2 public health nurses.

The county venereal disease clinic was held twice a month, and had an attendance of 56 on the day visited. Here a paid auxiliary worker spent a half hour in preparation for the clinic besides the 10 minutes spent by 1 public health nurse.

The 2 state-administered venereal disease clinics had 4 and from 8 to 9 sessions per month respectively, and 42 and 14 patients respectively on the day of the surveyor's visit. In 1 of these state clinics, a paid auxiliary worker spent 3 hours and a clerk 10 minutes in preparation for the clinic besides the 10 minutes given by the public health nurse. In the other, a paid auxiliary spent 1 hour getting ready for the clinic.

TABLE IV. PUBLIC HEALTH NURSING TIME BEFORE THE CLINIC SESSION

Type of clinic	Median		Highest		Lowest (other than none)	
	Hours	Minutes	Hours	Minutes	Hours	Minutes
All clinics	....	43	16	....	....	10
Child health	2	32	5	....	....	10
Crippled children's	....	36	16	....	....	30
Maternity	1	2	4	....	....	15
Tuberculosis	....	40	6	....	....	15
Venereal disease	....	38	6	....	....	10

TABLE V. PUBLIC HEALTH NURSING TIME DURING THE CLINIC SESSION

Type of clinic	Median		Highest		Lowest (other than none)	
	Hours	Minutes	Hours	Minutes	Hours	Minutes
All clinics	4	44	50	....	....	30
Child health	4	28	35	....	1	30
Crippled children's	7	....	50	....	1	....
Maternity	5	12	24	....	...	30
Tuberculosis	4	45	16	....	1	....
Venereal disease	4	31	42	....	....	30

TABLE VI. PUBLIC HEALTH NURSING TIME AFTER THE CLINIC SESSION

Type of clinic	Median		Highest		Lowest (other than none)	
	Hours	Minutes	Hours	Minutes	Hours	Minutes
All clinics	....	45	16	....	....	10
Child health	....	43	3	....	....	10
Crippled children's	2	38	16	....	....	30
Maternity	1	7	5	30	....	15
Tuberculosis	....	53	13	....	....	15
Venereal disease	....	35	4	30	....	10

It is interesting to note that in both of these state venereal disease clinics, the paid auxiliary worker gave service only before and after the clinic, whereas in the county clinic she served before, during, and after the clinic session.

During the Clinic. During the session (Table V), the highest amount of public health nursing time was 50 hours, also in a crippled children's clinic, conducted once a year by a state non-public health agency. This time was divided among 6 public health nurses, and the number of patients cared for was 95. Besides 1 physician and 6 public health nurses, the personnel during the clinic session comprised a nutritionist, a clerk, and 15 volunteer workers.

The lowest amount of public health nursing time was 30 minutes, in 1 maternity clinic held once a week, and in 1 venereal disease clinic held 3 times a week, both located in the same state but under separate local agency administration.

In the maternity clinic, located in a hospital, there were 14 patients on the day visited and a hospital nurse, clerk, and student nurse each gave one-half hour's service plus the 30 minutes given by the public health nurse.

In the venereal disease clinic conducted by a local health department with public health nursing personnel supplied by a visiting nurse association from a city nearby, only 9 patients were seen on the

day of the survey, and the doctor and public health nurse were the only workers present.

After the Clinic. Public health nursing time spent in post-clinic session activities (Table VI) ranged from 16 hours in a crippled children's clinic conducted once a month, administered by a state department of public welfare, to 10 minutes spent in a child health conference also conducted once a month, administered by a county health department, and 2 venereal disease clinics—one administered by a county and the other by a state health department. The latter were held 3 times a week and once a week respectively.

In the child health conference, the 10 minutes was divided between 2 public health nurses, and there was no other personnel for post-clinic activities. The attendance was only 5 on the day of the visit.

In the state venereal disease clinic, a paid auxiliary worker spent 3 hours. In the county venereal disease clinic, a clerk spent one-half hour and a paid auxiliary worker three-quarters hour in addition to the 10 minutes spent by the public health nurse. The attendance at these 2 clinics was 42 and 56 respectively at the time of the survey.

From the estimates and time studies, it would appear that the median proportion of time consumed by clinic service of total public health nursing time is slightly more than one fifth. Together with the present wartime trend towards greater use of health centers for conserving travel time of physicians and nurses, emphasis must also be placed upon the full utilization of the opportunities for service and education thus available to the patient who comes to the center, instead of being visited in his home. If the clinic is thus fully utilized, this proportion of public health nursing time is probably well spent.

According to the surveyors' records the median amount of public health nursing time spent in all the clinics surveyed was 43 minutes before; four hours and 44 minutes during; and 45 minutes after the clinic session.

By types of clinics, the median was lowest for child health conferences and venereal disease clinics in preparation for and after the clinic session, and for maternity and venereal disease clinics during the session. The largest median amount of public health nursing time before, during, and after clinics occurred in crippled children's clinics, probably accounted for by the nature of the service but also by the fact that the clinic sample included many state-administered crippled children's clinics some of which were held only once or twice a year, in one instance only once in two years.

5. Clinic Personnel

In addition to physicians, 18 different kinds of workers representing 104 combinations were found to be participating before, during, or after the clinic session—nurses, clerks, volunteers, paid auxiliary workers, student nurses, X-ray technicians, physical therapists, dentists, nutritionists, dental hygienists, occupational therapists, laboratory workers, social workers, custodians, orderlies, bacteriologists, nursery school teachers, and in one instance, a sexton.

Three or more kinds of workers, including the physician, were found in 94 percent of the clinics. The largest number at a single session was 25 workers of 6 different kinds in a crippled children's clinic administered by a state crippled children's commission once a year and held in a church. Fifteen of the 25 workers were volunteers, 6 were public health nurses, and the remaining 4—a physician, a nutritionist, a clerk and an additional paid helper. The attendance at the time this clinic was visited was 95.

The largest variety of workers encountered in any clinic was 10—physician, public health nurse, non-public

health nurse, clerk, physical therapist, X-ray technician, medical social worker, student, bracemaker, and volunteer. These ten worked in a crippled children's clinic administered by a state department of education, conducted once a week. No information was given about attendance. Another example of a large variety of workers was found in a child health conference administered by a voluntary babies' hospital in a large city, conducted 5 days a week with an average attendance of 31. Here there were a physician, public health nurse, non-public health nurse, nutritionist, dentist, dental hygienist, paid auxiliary, volunteer and clerk.

The smallest number of workers found in any clinic was 2—a physician and a nurse—a combination which appeared in 19 clinics—12 tuberculosis, 5 venereal disease, and 2 maternal care. The most frequent single combination consisted of 3 workers—a physician, public health nurse, and volunteer or clerk.

NURSES

Distribution. The distribution of the 734 nurses working in the clinics at the time of the survey is shown in Table VII.

The proportion of non-public health nurses in all clinics is relatively small. They worked more often in types of clinics where diagnosis and treatment predominated, such as venereal disease, maternity, tuberculosis, and crippled children's clinics, than in child health conferences where education and prevention were the chief or sole objectives.

Education and experience. Comparisons of certain educational and professional qualifications of the nurses working in the clinics in the present survey (1942) with those employed in the public health agencies included in the survey of public health nursing made by the National Organization for Public Health Nursing in 1932 are shown in Table VIII.

That gains have been made in the 10-year interval between the two surveys, both in respect to higher general education and preparation for public health nursing through programs of study and public health nursing experience, is apparent from this comparison. But it is significant, also, in considering the role of nurses in clinics that less than one third of the 1942 sample have completed programs of study in public health nursing, and only slightly more than one half have had previous public health nursing experience. If the primary function of the nurse in the clinic is educational through various direct and indirect approaches, higher general education as represented by college graduation as well as study in public health nursing is probably a fac-

TABLE VII. KIND OF NURSE BY TYPE OF CLINIC

Kind of nurse giving service	Total all nurses		Type of clinic									
			Child health		Crippled children		Maternity		Tuberculosis		Venereal disease	
	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent
Total all nurses	734	100	144	100	71	100	183	100	123	100	213	100
Public health nurses giving clinic and field service	602	82	142	99	60	84	145	79	102	83	153	72
Public health nurses giving clinic service only	38	5	1	1	....	....	16	9	7	6	14	7
Non-public health nurses giving clinic service only	94	13	1	1	11	16	22	12	14	11	45	21

TABLE VIII. COMPARISON OF CERTAIN QUALIFICATIONS OF NURSES—1932 AND 1942

Qualifications	Nurses in 1942 clinic survey			Nurses in 1932 NOPHN Survey[1]		
	Total in sample	Number	Percent	Total in sample	Number	Percent
Graduation from college[2]	642	94	15	822	20	2
Completion of program of study in public health nursing	710	228	32	823	56	7
Public health nursing experience prior to present position	729	389	53	818	209	26

[1] National Organization for Public Health Nursing. Survey of Public Health Nursing. The Commonwealth Fund, New York, 1934, p. 25.

[2] Exclusive of program of study in public health nursing.

tor of some weight in the adequacy of her performance.

The highest proportion of college graduates, and of those with prior public health nursing experience, were among public health nurses giving clinic service only. It must be remembered, however, that the number of nurses in this group is relatively small, and that some supervising personnel is undoubtedly included.

On the other hand, a slightly higher proportion of those who had completed a program of study in public health nursing were found among public health nurses giving both field and clinic service, 36 percent, than among those giving clinic service only, 34 percent. It is noteworthy that 7 percent of the nurses having the functional or pay-roll title of non-public health nurse had completed a program of study in public health nursing.

Information about advanced preparation in special clinical fields was not secured in 1932, but in 1942 it was found that 90, 13 percent, of the nurses about whom this information was available had such preparation. More public health nurses giving clinic service only had it, 19 percent, than those giving both clinic and field service, 14 percent, or non-public health nurses, 8 percent.

Obstetrical, venereal disease, and orthopedic nursing were the three fields in which approximately two thirds of these 90 nurses had had advanced study. This may be accounted for by the fact that state-federal stipends through the Social Security Act have for several years been available to personnel of tax-supported agencies for further study in these three fields. It is nevertheless interesting to note that although more than 90 percent of the clinics surveyed were administered by tax-supported agencies, only 8 percent of all nurses had had this advanced preparation.

Salaries. Information in regard to salaries paid the nurses serving in the clinics studied was considered relevant to this discussion of qualifications.

Monthly salaries paid the 190 public health nurses employed full-time ranged from a minimum of $100 to a maximum of $200 with a median of $143. This median is slightly higher than the median salary of $140 based on the monthly salaries of 6,040 general public health staff nurses in the agencies of various kinds which responded to the NOPHN 1942 Yearly Review. Salaries received by the 60 non-public health nurses employed full-time were noticeably lower, ranging from less than $70 per month to a maximum of $160, with a median of $113.

VOLUNTEER WORKERS

Because of the present widespread interest in the extensive contribution which volunteer workers are making to public health services, particular inquiry was made in regard to their activities in clinics. Volunteer workers were found in 111, 52 percent, of all the clinics sur-

veyed, the proportion being largest among those conducted by non-official public health agencies and smallest among those of tax-supported hospitals.

According to the data obtained about volunteer workers in each type of clinic, they were found most often working in child health conferences, in fact in 65 percent of those surveyed; and in 60 percent of crippled children's clinics. They were assisting in only 40 percent of maternity clinics and in only 19 percent of tuberculosis clinics. Only 2 venereal disease clinics, or about 4 percent of the sample, reported the use of volunteer workers.

PAID AUXILIARY WORKERS

The use of paid auxiliary workers was reported by 78, 42 percent, of the 186 clinics about which this information was obtained.

More maternity and tuberculosis clinics, 53 and 50 percent respectively, employed paid auxiliary workers than did venereal disease clinics, 45 percent; crippled children's clinics, 33 percent; and child health conferences, 35 percent.

6. Some General Characteristics of the Clinics

Five types of clinics and health conferences were included among the 212 surveyed: 58 child health, 28 crippled children, 37 maternity, 32 tuberculosis, and 57 venereal disease clinics. These were distributed among the 9 United States census divisions and 38 states and the District of Columbia. Entire or parts of cities, counties, towns, and villages were served by these clinics, but five sixths, 85 percent, were located in urban communities.

The clinics were more often situated in governmental buildings used also for other activities than in separate health agency buildings or in hospitals. Over one third were distributed among a variety of quarters, including business buildings, community centers, private dwellings, schools, nursing offices, churches, lodges, and libraries.

Eighty-five percent of the clinics surveyed were administered by public health agencies and only 15 percent by hospitals. Health departments were largely responsible for the administration of the clinics surveyed. They fell into two general classifications as far as admission policies were concerned, those open to all regardless of economic status, and those open only to families judged unable to afford a private physician. Some modifications or exceptions to these general policies were encountered in about one fourth of the total number. Child health conferences, where educational and preventive services predominated, less often had restrictive policies as to admission than other types of clinics which offered diagnosis and treatment for specific health conditions.

Exclusive of the clinics open to all, eligibility of patients for service was judged by a variety of personnel in the 110 clinics about which this information was obtained: by a public health nurse alone in 34; by a social worker alone in 24; by a physician alone in 15; and by combinations of all three of these workers in 19. In 18, this function was performed by others, such as personnel of the administrative or admitting office, agency board members or central office staff, the medical society, a health center committee, the public welfare department, a registrar or rate adjuster, or volunteer workers.

No fee was charged for service in the large majority of clinics, about 85 percent. The highest amount charged was $1 and the lowest 15 cents. Official agency clinics, particularly those for patients with venereal disease, rarely made a charge.

Physicians were quite generally paid for their services in all types of clinics, and without exception in venereal disease clinics.

Seventy of the 212 clinics surveyed were reported to serve as teaching or observation centers for student nurses, or public health nurses, most often those administered by a combination of official and non-official agencies. Child health conferences and venereal disease clinics more often served this purpose than other types surveyed.

SUMMARY OF CONCLUSIONS

1. Eliminating from the duties of the public health nurse all activities which auxiliary workers or non-public health nurses might perform instead is needed to provide greater opportunity for and more concentration upon the educational aspects of the clinic.

2. Auxiliary workers, paid or volunteer, should be utilized in all types of clinics and for all types of work which do not require the judgment, knowledge, and skills acquired through professional training.

3. Professional nurses without public health nursing preparation seem to be needed in addition to public health nurses and auxiliary workers in large clinics where numerous technical procedures are involved in diagnosis, tests, and treatment, such as venereal disease, tuberculosis, and maternity clinics.

4. Because of the importance of efficient clinic management and of teaching, only nurses who are thoroughly qualified for public health nursing should be employed for these services in clinics. This applies particularly to departments of health, since they are so largely responsible for clinic administration.

5. Analysis of clinic activities performed by nurses as well as other personnel, combined with time studies, might well be undertaken by all agencies administering a clinic program, as a basis for reassigning duties where necessary and conserving nursing time.

6. Through the assignment of non-nursing duties to other personnel, the amount of public health nursing time before and after the clinic session, *i. e.*, before medical service begins and ends, can be reduced by as much as two thirds.

7. Continued attention is urged to ways of including as much as possible progressive health educational and psychological and social content and method in the basic nursing and public health nursing curriculums.

This is the conclusion of the Clinic Study report, the first part having appeared in the May issue of the Magazine, page 209.

HOW TO MAKE A SPEECH AND ENJOY IT

HEALTH and welfare workers have long waited for a helpful book on public speaking. Now at last one is ready—"How to Make a Speech and Enjoy It" by Helen Partridge, illustrated by Mary Stevens.

The book starts where most speeches start—with stage fright. It tells how to fight off those anticipatory chills and fevers (most people suffer them before making a speech—even the most famous public speakers). Almost every point about speech-making is covered—how to visualize your audience while preparing the speech, how to put punch into that opening sentence, how to use tested devices for holding attention, how to plan the windup, and how to polish the speech once it is down on paper.

As a special service to its members the NOPHN is offering copies for sale at 50 cents each (to non-members 75 cents a copy). This has been made possible through a special arrangement with the National Publicity Council. Write NOPHN, 1790 Broadway, New York 19, N. Y., for your copy. Every public health nurse should have a copy in her library.

Alcohol Research---Theoretical and Practical

By E. M. JELLINEK, Sc.D.

Part II

IN THE quaint old building which once was the residence of Mr. Sheffield, the founder of the Sheffield Scientific School, intensive experimentation on the physiology of alcohol has been carried out since about 1930 by Dr. Howard W. Haggard and his associates. In the course of the years, Dr. Haggard came more and more to the conviction that physiology by itself could not contribute essentially toward the solution of the alcohol problem, but that this goal could be achieved only through an integration of researches from many branches of science. As a first step the *Quarterly Journal of Studies on Alcohol* was founded to carry scientific papers on all aspects of the problem of alcohol which had been widely scattered over chemical, physiological, psychiatric, medical, psychological and law journals. The student of an aspect of alcoholism hardly ever saw his special field of investigation in relation to the other fields of alcohol research. These interrelations stand out sharply in the first four volumes of this new periodical which opened its pages to the objective discussion of the full range of alcohol problems, from chemistry to taxation policy. As a second step, Dr. Haggard gave me a free hand in organizing a unit in which representatives of sociology, psychiatry, psychology, jurisprudence, economics and statistics would cooperate on alcohol researches and on their practical application in education and therapy. This unit, which is frequently referred to as the School of Alcohol Studies, is officially known as the Section on Alcohol Studies of the Laboratory of Applied Physiology, and comprises a research group, as well as the Summer School of Alcohol Studies and the Yale Plan Clinics.

Because of your specific interests, I shall say more about the Clinics than about the Summer School and our research projects. I cannot neglect the description of the researches entirely, since the school and the Clinics attain full significance only in relation to the total program. The complexity of the alcohol problem demands a multiplicity of approaches.

The statement that the alcohol problem cannot be solved by statutes alone but that it requires broad social measures, economic readjustments, education of the individual and of society, as well as rehabilitation of the inebriates, does not mean that it is sufficient to carry out such measures simultaneously, but that these measures must be brought into relation to each other. It is useless to go in for mass rehabilitation of alcoholics if it is not considered that the stigma that attaches to them may be a barrier to bringing them back into the community. This requires sociological research into the roots and nature of this particular stigma, and educational research into the ways

and means of adjusting the difficulties arising from stigma. Educational research on this subject would be meaningless without the utilization of the sociological data pertaining to it. On the other hand it would be useless to limit by regulation the supply of alcoholic beverages without rehabilitating the habitual inebriates who constitute a ready market for illicit supplies.

Studies of Legal Control

Instead of describing our legal researches I shall rather touch upon the principles guiding us in this matter. In his book, *Liquor Control* (1931), G. E. G. Catlin says: ". . . this question [legal control] has usually been approached neither from the side of the empirical test of the social results—of 'learning by doing'—nor from the side of research into the permanent physiological, psychological and social causes of the trouble, but from the side of abstract principle." It is this "abstract principle" from which we wish to emancipate ourselves in legal research, without losing sight of the fact that legislative action cannot be divorced from legal thought and legal systems. We wish to analyze to what extent existing or past statutes are rooted in social factors, or are unconnected with them; to what extent statutes aim at what society expects of them and believes to be their goal. We want to test the effectiveness of statutes in terms of indexes of inebriety such as deaths from alcoholism, alcoholic mental disorders, and related manifestations. Foremost, we want to analyze the reasons of success and failure of identical statutes in different localities, i. e., the dependence of success and failures upon the way the statutes are handled, and upon the social factors prevailing in the locality. We want to uncover those social factors which tend to weaken or to reinforce the law in action.

The objects of our sociological and psychological research blend, to a considerable extent, with the objects of our legal research. We are investigating not merely inebriety, but the complex of which inebriety is an aspect. We are interested in the function of alcohol in society, that is, in the uses to which society puts it, consciously or unconsciously. We must know what abstinence, and what moderate and immoderate use of alcoholic beverages, signifies to society or groups of society in terms of prestige, fellowship, need for the occasional relaxation of certain social rules, as well as in terms of rightly or wrongly attributed virtues and dangers. If the handling of the problem of alcoholism is to be based on knowledge, we must know to what extent and by what means society exploits, on the one hand, and attempts to control, on the other hand, the effects of alcohol. And we must study the anomalies of action and of attitude which may arise from the possible conflict of these two opposing trends.

These objectives are to be achieved through carefully designed field surveys such as that conducted by Dr. Selden D. Bacon on drinking habits in New Haven, or our geographically more scattered survey of the experience of ministers with individual problems of alcoholism. The extreme form of inebriety is the object of our study of alcoholic derelicts turning up at the Salvation Army.

The role of environment in inebriety has been often postulated but not tested. The high incidence of child mortality, delinquency, alcoholism, and other psychologically deviant behavior among the offspring of alcoholic parents was first attributed to germ damage by alcohol, but later explained as the outcome of neglect and bad example. Dr. Anne Roe is completing a study of foster children originating from alcoholic, psychotic and normal parents and placed into normal foster homes. These foster children are now between 30 and 40 years old and their social adjustment can be well evaluated.

This project should contribute significantly toward the understanding of the role of environment in the alcoholism of the offspring of inebriates.

Incidentally, the field surveys which we intend to carry out in many sections of the United States contribute toward gaining a correct estimate of the magnitude of the problem. Such estimates have no justification as an end in themselves, but if public recognition of research, which is indispensable to the progress of science, is to be sought, there must be reliable estimates which neither minimize nor exaggerate the problem. Some of our economic researches on the expenditure involved in inebriety and on the per capita expenditure on alcoholic beverages are largely intended to substitute scientific fact in place of guessing.

These are only a few of the many research projects in process or contemplated.

Studies in Education

The educational activities of the Section on Alcohol Studies embrace research on methods in alcohol education as well as the practice of education in this field. The research is directed toward the kind of material that is appropriate for presentation and the ways of presenting it. Dr. Roe's survey of school texts relating to this subject has indicated the cogency of such research. While these researches are under way, we are not refraining from practical education. The *Lay Supplements* published by the *Quarterly Journal of Studies on Alcohol* are intended to present the results of modern research in simple language to the interested layman. In order to cut out the large lag between research and public knowledge, a *Popular Digest of the Quarterly Journal of Studies on Alcohol,* as well as an abridged edition of the Summer School lectures, will be published yearly. Intelligent thinking and action in relation to the problem of alcohol requires an understanding of the ramifications of the problem and its close relation to other social issues. Education of society, in the best sense of the word, can be carried out only by those who have grasped these complexities and are in a position to apply the conclusions where they are most needed. The education of society must go far beyond the apparent confines of the alcohol problem in order to have any repercussions in social attitudes toward inebriety. In order to fulfill this requirement the Summer School of Alcohol Studies gathers men and women who, through their activities, are in a position to shape the activities in their communities. Ministers, teachers, health and welfare workers, temperance workers and law enforcement officers are given a course designed to illustrate the complex nature of the alcohol problem rather than to enlarge on technical details of one or more of its aspects. Discussion seminars serve to develop the objective attitude which is indispensable in utilizing the acquired knowledge.

The curriculum of the Summer School, after considering the physiological and psychological effects of alcohol, leads over to those individual and social factors which determine the nature and extent of the utilization of these effects. Use and abuse of alcohol are shown as resultants of the interplay of individual social and economic factors rather than as a result of any one of them. While this part of the curriculum deals with inebriety as a mass phenomenon, the individual problem of alcoholism is also covered. The questions of the treatment of compulsive drinking, and the rehabilitation of the alcoholic, the role of psychotherapy and drug therapy, the functions of the minister, of the lay therapist, and of such groups as Alcoholics Anonymous are all considered.

That we devote much time and attention to alcohol education of society and the rehabilitation of the inebriate does

not signify our belief that these are the most important steps in the handling of the alcohol problem, but that they represent for the time being the most feasible ones. Because of this we have widened our activities through the addition of clinics for the diagnosis and guidance of inebriates.

Yale Plan Clinics

In setting up the Yale Plan Clinics at Hartford and New Haven, we had more than one objective in view, and it is hard to say what the foremost objective is. It would seem obvious that the most important function is to help the individual inebriate. I feel, however, that, for the time being at least, an equally important object of the Clinics is to impress on public opinion the idea that alcoholism is a public health problem, that the alcoholic, as a rule, is not a hopeless moral pervert, but a person afflicted with a disorder which can be checked if treated appropriately. Unless these ideas are accepted by the general public, the rehabilitation of alcoholics will be limited to individual instances. The orientation of public opinion in these matters is a legitimate and feasible function of the Clinics. The contact which the Clinics are developing with members of the judiciary, probation officers, police, sheriffs, health authorities, the clergy, teachers, and others active in community life, will aid in changing the penal attitude toward the alcoholic into a medical attitude. But in addition the Clinic staff must make a systematic effort to convey these ideas by means of popular literature and lectures.

The Clinics should serve the individual alcoholic and his family, but they should also constitute a demonstration of the community service which scientists can offer. In this sense the Clinics are an experiment. One function of our two Clinics is to develop, from their experience, from their successes and failures, a basis for the future pattern of public care. The experience of the Clinics will become available to others through publications, but the Clinic staff will always be ready to act as advisers to authorities or organizations on matters relating to the rehabilitation of alcoholics.

The Clinics are an integral part of our program, not only in the sense that they contribute one of the many steps directed toward the prevention of inebriety but also in the sense that the social and psychiatric case histories gathered there furnish new research material related to the origin of compulsive drinking.

Whether one or another of the objectives is theoretically more important, the fact remains that, in practice, only the actual activities with patients can lead to the desired objectives.

Treatment of Inebriety

The question may be raised why we advocate clinics limited to diagnosis and recommendations, instead of creating an institution for the treatment of inebriates.

As research on inebriety has progressed, it has been realized more and more that there is not one kind of inebriety, but several, and that each kind requires its own type of treatment. It is true that this has been realized only by students of the problem, and that the recognition of this fact has not even penetrated into the widest circles of the medical profession. Not only are there several types of inebriety requiring different methods of treatment, but there are also certain forms of inebriety which are of such a secondary nature that they cannot be considered for treatment at all. Insufficient consideration has been given hitherto to the fact that when excessive drinking occurs in persons with a mental disorder, such as early general paresis or early dementia precox, or in feeble-minded persons, the inebriety cannot be regarded as a disease in itself but only as a symptom of the underlying mental disorder or defect. It is useless to treat symptoms; to

be effective, treatment must be directed at the underlying disorders. There have been some institutions for inebriates, in the past, to which feeble-minded and psychotic drinkers were admitted together with the true inebriates. These patients received only custodial care or, if treatment was attempted, the same methods were applied to all. Under such circumstances, it is not surprising that the special institutions failed. Custodial care is no treatment at all, and it is unjustifiable to evaluate the therapy of inebriety on the basis of data pertaining to custodial care. Such assessments, however, are prevalent in the literature of the treatment of inebriety. It is equally unjustifiable to evaluate the efficacy of a method of treatment when it has been applied to a disorder for which it was not devised. Evaluations of this sort, however, are the most frequent in the literature. There are persons who take recourse to intoxication because of deeplying personality conflicts which become temporarily resolved in the course of intoxication. These persons may benefit from deep-searching psychotherapy, but they could not be helped by a drug treatment since the drug could not do away with the underlying personality conflicts. There are persons who become dependent upon alcoholic beverages, not on the grounds of any personality deviations, but rather in the course of heavy drinking which may be in accord with the customs of their social set. Psychotherapy in these instances is of little avail because there is no underlying personality conflict which could be removed by the psychotherapy. In these cases, according to various indications, either drug therapy or occupational therapy may be helpful. Or, if there is some psychological readiness for religious experience, a course such as that taken by Alcoholics Anonymous may be the most promising. There are many more types of inebrieties than those mentioned here, but it is not the object of the present discussion to elaborate this question. The success of treatment depends in the first place on the determination of the kind of inebriety that is manifested by the patient. The diagnosis can be made only by highly specialized experts. A psychiatrist who has dealt with psychotic drinkers only would not have the necessary experience for recognizing the other types. The diagnostician of inebriety must have had the widest possible experience and, at the same time, he must have a thorough grounding in the theory of inebriety.

The creation at this time of an institution which could carry out all the treatments, according to the requirement of the patient, would be difficult and extremely expensive. It is also doubtful whether our present knowledge of treatment would justify the establishment of such an institution. It seems that the most practical procedure at present is to create centers where highly experienced diagnosticians can study the patient, determine what his type of inebriety is and the kind of treatment which he requires, and utilize the existing resources of the community for the most appropriate disposition of the case. If this is done, the Yale Plan Clinics cannot be said to be stopping at diagnosis and advice. I may mention that in some instances treatment is given at the Clinics. We must be prepared to meet with an indigent compulsive drinker for whom intensive psychotherapy seems to be the only appropriate procedure. It would be useless to advise him to seek treatment which he cannot afford; we must, in such a case, provide treatment at the Clinic.

The procedures at the Clinics are as simple as possible. A telephone call suffices to make an appointment with the psychiatrist or the social worker. The general public knows of the existence of the Clinics through newspaper publicity; the judiciary, police, welfare and social

(Continued on page 301)

Reviews and Book Notes

MANAGING YOUR MIND

By S. H. Kraines, M.D., and Eloise S. Thetford. 374 pp. The Macmillan Company, New York, N.Y., 1943. $2.75.

This book should be very helpful to the public health nurse. The authors propose to demonstrate the validity of the thesis that "our emotional states as definitely determine the well being of our bodies as they reflect it," and to "give a detailed explanation of the technique whereby you can control the situation."

The first part of the book provides an elementary review of recognized psychological theories and mechanisms together with a summary of altered physiological functions which produce bodily symptoms of sickness or of mental distress. The case histories and simple explanations give the nurse a means for insight into and control of her own mental problems as well as a basis for understanding the psychoneurotic symptoms observed in her patients. While the book could be given to persons of good education as a guide to healthful emotional living, it would need interpretation for effective use by most persons the nurse meets in the clinic and hospital or in the home.

While some of the concepts of Freud and the terminology of the psychoanalyst appear throughout the book, the omission of the "unconscious" will be a relief to many readers. The importance and place of sex and marriage is not overlooked but the authors label as absurd the " 'modern' who insists on reading sexual implications in everything from the distorted elements of a fantastic dream to the innocent play of children."

The possibility of managing one's mind is indicated in a series of chapters showing the contribution to healthful living which can be made by a realistic philosophy of life, maturity and stability, sex and marriage, and self reliance and courage.

The authors have used case anecdotes to illustrate the mobilization and wise use of latent energy to make the most of situations and to achieve desirable personal and social goals.

The nurse will find this second part of the book most useful as a guide to the practice of mental hygiene. She will want to reread many of the chapters in the light of problems arising in her professional practice or in her own living.

HENRIETTA ADAMS LOUGHRAN
Boulder, Colo.

AN INTRODUCTION TO SOCIOLOGY AND SOCIAL PROBLEMS: A TEXTBOOK FOR NURSES

By Deborah MacLurg Jensen, R.N., B.Sc., M.A. 420 pp. C. V. Mosby Company, St. Louis, Mo., 1943. 2nd edition. $3.25.

The first edition of this text was published in 1939. In the second edition, chapters have been added on the Social Security Act, the National Health Program, the Child in Wartime, and Working Mothers. The addition of a glossary of terms frequently used and a list of agencies and associations in the general fields of health and welfare enhance the value of the book. It is intended as a text for the student in the basic program in Nursing Education and may also be used as a reference book.

The book is divided into eleven units and at the close of each the author has given a list of questions for review and study, as well as a list of suggested projects. The excellent bibliography at the end of each unit has been brought up to date. The book is especially to be

commended for its interpretation of the many phases of social problems with which the nurse is continually confronted.

AURELIA B. POTTS *(Posthumous)*
Nashville, Tenn.

TUBERCULOSIS, LABOR AND MANAGEMENT

By William Arkwright Doppler, Ph.D. 52 pp. National Tuberculosis Association, 1790 Broadway, New York 19, N.Y., 1944. To obtain, consult your state or local tuberculosis association.

How to go about planning a tuberculosis program in industry, where to go for information, with whom to work, and how to stimulate interest in pre-placement and periodic examinations, including a chest X-ray, are told in this booklet, which is a practical guide to industrial and public health nurses and tuberculosis associations. Each chapter ends with a "1, 2, 3" plan for dealing with the questions taken up in that chapter.

Mr. Doppler, the author, places emphasis on human relations, showing the importance of obtaining the cooperation of labor, management, the medical profession, and voluntary and official public health agencies.

In a chapter on compensation he states that the experience of some of the largest carriers of industrial liability insurance shows that the X-raying of large industrial groups produces no compensation situation that works hardship on employers, employees or insurance companies.

The author believes that the cost of X-rays should be borne jointly by the worker, his union, the employer, the health department and the local tuberculosis associations which are able to allocate seal sale funds for demonstration. The importance of a program of education before X-ray surveys are made is stressed. Handling of arrested cases, treatment for workers found to have tuberculosis, financial aid for their families, and planning for rehabilitation are all considered as part of an X-ray program.

This is the first of a series of pamphlets on tuberculosis in industry.

L.L.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

STAFF EDUCATION AND SUPERVISION

INTERVIEWING: ITS PRINCIPLES AND METHODS. Annette Garrett. Family Welfare Association of America, 122 East 22 Street, New York, N.Y., 1942. 123 pp. $1.

This book is generally considered a classic in the social work field and it is well worth study by every public health nurse.

HEALTH EDUCATION

FIRST STEPS IN HEALTH EDUCATION: A GUIDE. Metropolitan Life Insurance Company, 1 Madison Avenue, New York, N.Y., 1943. 31 pp. Free.

MENTAL HYGIENE

PSYCHOLOGY AND THE NURSE. Frank J. O'Hara, C.S.C., Ph.D. W. B. Saunders Company, Philadelphia, 1943. 2nd edition revised. 258 pp. $1.75.

STATISTICS

UNIT MEDICAL RECORDS IN HOSPITAL AND CLINIC. Dorothy L. Kurtz. Columbia University Press, New York, N.Y., 1943. 110 pp. $2.

GENERAL READING

SONGS OF THE NIGHTINGALE: AN ANTHOLOGY OF POETRY COMPOSED BY THE NURSES OF AMERICA. Harbinger House, 381 Fourth Avenue, New York, N.Y., 1943. 3rd series. 174 pp. $3.

A number of public health nurses are included among the authors represented.

THE FIRST WOMAN DOCTOR: THE STORY OF ELIZABETH BLACKWELL, M.D. Rachel Baker. Julian Messner, Inc., New York, N.Y., 1944. 246 pp. $2.50.

NURSING EDUCATION

A TEXTBOOK OF PRACTICAL NURSING. Kathryn

Osmond Brownell, R.N., B.S. W. B. Saunders Company, Philadelphia, 1944. 2nd edition, revised. 411 pp. $3.

CHILD HEALTH

GUIDING THE NORMAL CHILD: A GUIDE FOR PARENTS, TEACHERS, STUDENTS AND OTHERS. Agatha H. Bowley, Ph.D. Philosophical Library, New York, N.Y., 1943. 174 pp. $3.

The viewpoint of this English book is helpful although the material is brief. A chapter on children and the war is included.

CORRECTION: Single copies of the brochure, "Industrial Nursing in Connecticut," which was compiled by the Industrial Nursing Section of the Connecticut State Nurses' Association in cooperation with the Bureau of Industrial Hygiene of the Connecticut State Department of Health, may be obtained from the Connecticut State Nurses' Association, 252 Asylum Street, Hartford, Connecticut, free of charge, with a charge of ten cents each for five or more copies, rather than through the Bureau of Industrial Hygiene as stated in the May 1944 issue of PUBLIC HEALTH NURSING, page 251.

Hazel V. Dudley is the author of a resumé of the "Survey of Industrial Nursing in Connecticut" which appeared in the February 1944 issue of the *Connecticut Health Bulletin*, and is not the author of the brochure, "Industrial Nursing in Connecticut." Mimeographed copies of a fuller report of the "Survey of Industrial Nursing in Connecticut" are available free through the Bureau of Public Health Nursing, Connecticut State Department of Health.

Alcohol Research

(Continued from page 298)

agencies in Hartford and New Haven have been informed of the objects and procedures in special conferences. Other sources of referrals of patients get acquainted with the Clinics through direct descriptive leaflets. The Clinics become more widely known and are more widely utilized from day to day. Patients are referred to the Clinics by courts, welfare and social agencies, by visiting teachers and visiting nurses, ministers in parishes, general hospitals, and private practitioners. Many alcoholics come to the Clinics on their own initiative, and there has developed a considerable consulting service for relatives and friends of inebriates. The services rendered by the Clinics are free of charge.

The patient entering the Clinic is given a physical examination, and is then studied by a psychiatrist and a social worker. Proper diagnosis and recommendation of treatment may require several visits at the Clinic. The recommendations based on these studies relate to the treatment of compulsive drinking as well as to the correction of physical ailments attendant upon excessive drinking. The greatest effort is made to make it possible for the patient to follow the advice. It is intended to follow up the results of the advice given and thus to learn about the effectiveness of our plans, their weaknesses and values.

The time and detail which I have devoted to the Clinics should not lead the reader to think that we attach more importance to this phase of our work than to our other researches and activities. It is the special interest of the health and social agencies that I am addressing which has induced me to expand on the clinic idea. In our own scheme of affairs the Clinics play no greater role than any other of our approaches to the problem of inebriety.

The new trend of alcohol research, as reflected in the activities at Yale, is bound to furnish the knowledge and the orientation which will enable the public to deal rationally with that age-old problem which hitherto has defied the best intentions because they were subjectively oriented efforts.

HELP IN THE FIFTH WAR LOAN DRIVE—BUY A BOND TODAY!

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

AGENCY MEMBERS

In accordance with a new policy, the names of all agencies admitted to NOPHN membership will be published in PUBLIC HEALTH NURSING Magazine as their applications are reviewed and accepted by the Eligibility Committee. Up to April 20, 344 agencies were NOPHN members. On that date, the Eligibility Committee admitted five more agencies: Alexandria Visiting Nurse Service, Inc., Alexandria, Virginia; Manhasset Health Center, Manhasset, New York; Marshalltown Community Nursing Service, Marshalltown, Iowa; Glen Cove District Nursing Association, Glen Cove, New York; and Glendale Community Visiting Nurse Association, Glendale, California.

For independent voluntary agencies to be admitted to NOPHN membership it is desirable that they shall:

1. Be administratively engaged in public health nursing service.
2. Be incorporated under the laws of the state.
3. Have a representative community governing group which holds regular meetings attended by the nurse director.
4. Have a medical advisory service and standing orders approved by the local medical group.
5. Employ a qualified nurse executive. (In small agencies—up to four or five nurses—the nurse executive may divide her time between administration, supervision, and some actual field work.)
6. Have qualified nurse supervision in the proportion of one supervisor to not more than ten field nurses, including students.
7. Employ only staff nurses who are eligible for full nurse membership in the NOPHN. (This applies only to those employed after 1940.)
8. Follow policies in relation to personnel and office management which are in accord with accepted current practice as indicated by the annual review of agencies and other studies made by the NOPHN.
9. Accept students in the proportion of no more than one student to three nurses in an urban agency, and no more than one student to one staff nurse in a rural agency.
10. Offer a planned program of staff education for the introduction of new nurses and the continuous guidance of all the staff.
11. Maintain a record system which includes activity and service reports.
12. Use the confidential exchange according to policies set up by the local public health nursing agency and the exchange.

For public health nursing service administered by health departments, boards of education, insurance companies, and the like, it is desirable that they shall:

1. Employ a qualified nurse executive. (In small agencies—up to four or five nurses—the nurse executive may divide her time between administration, supervision, and some actual field work.)
2. Have qualified nurse supervision in the proportion of one supervisor to not more than ten field nurses, including students.
3. Employ only staff nurses who are eligible for full nurse membership in the NOPHN (This applies only to those employed after 1940.)
4. Follow policies in relation to personnel and office management which are in accord with accepted current practice as indicated by the annual review of agencies and other studies made by the NOPHN.
5. If there is a student program, accept students in the proportion of no more than one student to three staff nurses in an urban agency and no more than one student to one staff nurse in a rural agency.
6. Offer a planned program of staff education for the introduction of new nurses and the continuous guidance of all the staff.
7. Maintain a record system which includes activity and service reports.

All of these qualifications together with more detailed information about NOPHN agency membership are given in a special booklet called Agency Membership in the NOPHN. Free copies are available from the NOPHN.

NOPHN NOTES

NOPHN STAFF FIELD SCHEDULE

Staff Member	*Place*	*Date*	
Mary C. Connor	Buffalo, N.Y.	June 3-8	University of Buffalo
			State Board of Nurse Examiners meetings and Biennial
	Orono, Maine	June	University of Maine
	Boston, Mass.	June 12-14	Simmons College
Ella Louise Gilmore	Bridgeport, Conn.	July	Advisory service to Visiting Nurse Association
Heide L. Henriksen	Winnipeg, Canada	June 12-15	Institute
		June 5	University of Buffalo
Hortense Hilbert	Erie, Pa.	June 13-15	Survey of public health nursing
	South Portland, Maine	June	A.W.C.S. matters
Mrs. Louise Lincoln	Chapel Hill, N.C.	June 12-28	Teach course in tuberculosis nursing
	Ann Arbor, Mich.	July 3-22	Teach course in tuberculosis nursing

In addition to visits appearing on the field schedule published in May, Ruth Fisher attended the National Conference of Social Work in Cleveland, Ohio, May 20-27. On May 11, Bosse B. Randle participated in the public health section meeting at the National Tuberculosis Association Convention in Chicago. On May 25-26 Dorothy Rusby made a survey of public health nursing services in St. Mary's, Pennsylvania.

MISS OTT JOINS STAFF

Margaret S. Arey, who has been the NOPHN assistant consultant in orthopedic nursing on the staff of the Joint Orthopedic Nursing Advisory Service since February 1943, last month assumed her new position as consultant in orthopedic nursing with the Massachusetts State Department of Health, Crippled Children's Division.

Katherine A. Ott replaces Miss Arey as Jessie L. Stevenson's assistant. Miss Ott had her basic nursing, public health nursing, and orthopedic nursing at Western Reserve University where she received her B.S. degree. She has a certificate in physical therapy from Harvard Medical School, a certificate in the Kenny technique of treatment for infantile paralysis from the University of Minnesota. Her previous positions have been with the Visiting Nurse Association of Cleveland and with the Division of Services for Crippled Children, Indiana State Department of Public Welfare, where she has been consultant in orthopedic nursing and physical therapy.

JONAS MATERIAL

The following publications have been prepared by JONAS for the National Foundation for Infantile Paralysis:

A Guide for Nurses in the Nursing Care of Patients with Infantile Paralysis. Publication No. 45 (revised).

A Guide for Parents in the Nursing Care of Patients with Infantile Paralysis. Publication No. 46 (revised).

Nursing Care of the Patient in the Respirator. By Carmelita Calderwood. Publication No. 49.

These may be obtained without charge upon request from the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York.

Loan folders on poliomyelitis with reprints of articles on the cause, treatment, and nursing care of infantile paralysis, together with bibliography, are available from JONAS, 1790 Broadway, New York 19, New York. The loan material may be kept for a period of two weeks, and the only charge is for transportation.

PAYMENT OF QUOTA DUES

In response to a letter asking public health nursing agencies who do not already pay full NOPHN quota dues to consider the possibility of doing so this year, 48 agencies up to May 1 had increased their 1944 dues. Successful fund-raising campaigns and increased fees from pay service have placed many agencies in a favorable position for paying the quota considered equitable for an NOPHN member agency—one percent of its total expenditure for nursing.

Comparison of the quota set for NOPHN member agencies and that for member agencies of five comparable national agencies reveals that the NOPHN quota is much lower.

Standards used for determining quotas vary, but in general quotas range from two to five

percent. One national agency similar to the NOPHN asks member agencies to make a quota contribution of one percent, but this is *in addition* to an annual membership fee.

NOPHN agency members who had increased their dues as of May 1 are:

CALIFORNIA
Long Beach Visiting Nurse Association
Oakland Visiting Nurse Association
Santa Barbara Visiting Nurse Association
Los Angeles Visiting Nurse Association

CONNECTICUT
Bridgeport—Public Health Nursing Association of Easton
Bridgeport—Visiting Nurse Association
Darien Public Health Association
Fairfield Visiting Nurse Association
Middletown District Nursing Association
New Britain Visiting Nurse Association
New Canaan Visiting Nurse Association

DELAWARE
Wilmington Visiting Nurse Association

ILLINOIS
Rockford Visiting Nurse Association
Decatur—Macon County Tuberculosis and VNA

INDIANA
Muncie Visiting Nurse Association

IOWA
Council Bluffs Visiting Nurse Association
Muscatine Public Health Nursing Association
Dubuque Visiting Nurse Association

MAINE
Portland District Nursing Association

MASSACHUSETTS
Pittsfield Visiting Nurse Association
Southbridge Visiting Nurse Association
Taunton Visiting Nurse Association
Watertown District Nursing Association

MICHIGAN
Bay City Public Health Nursing Service
Grand Rapids Community Health Service

MISSOURI
St. Louis Visiting Nurse Association

NEBRASKA
Omaha Visiting Nurse Association

NEW JERSEY
Bayonne Visiting Nurse Association
Hackensack—Central Bergen Visiting Nurse Service
Morristown Visiting Nurse Association
Palmyra Visiting Nurse Service

NEW YORK
Brooklyn Visiting Nurse Association
Jamestown Visiting Nurse Association
New Rochelle Visiting Nurse Association
New York—Community Service Society
Staten Island—Visiting Nurse Association

OHIO
Ravenna Visiting Nurse Association

PENNSYLVANIA
Hanover Visiting Nurse Association
Lancaster Visiting Nurse Association
Red Lion Visiting Nurse Association
West Hazleton Visiting Nurse Association

RHODE ISLAND
Pascoag—Burrville District Nurse Association

TEXAS
Dallas Visiting Nurse Association
Houston Visiting Nurse Association

VIRGINIA
Arlington Instructive Visiting Nurse Association
Richmond Instructive Visiting Nurse Association

WISCONSIN
Milwaukee Visiting Nurse Association
Racine Visiting Nurse Association

NOPHN HONOR ROLL

Up to the time the Magazine went to press 42 more agencies reported that all of the full-time nurses on their regular staff are 1944 NOPHN members. This makes a total of 171 agencies who have won a place on the NOPHN Honor Roll so far this year. Write NOPHN just as soon as your staff is 100 percent enrolled.

ARIZONA
Bisbee—Cochise County Health Service

COLORADO
*Denver—Metropolitan Life Insurance Nursing Service

CONNECTICUT
*Portland—District Nurse and Welfare Association

ILLINOIS
*Alton—Metropolitan Life Insurance Nursing Service
*Belleville—Metropolitan Life Insurance Nursing Service
*Oak Park—Metropolitan Life Insurance Nursing Service

INDIANA
Bedford—Lawrence County Nursing Service
*Evansville—Public Health Nursing Association
*Evansville—Public Schools
*Fort Wayne—Public Health Nursing Service of Fort Wayne and Allen County, Inc.
*Logansport—Metropolitan Life Insurance Nursing Service

IOWA
*Davenport—Visiting Nurse Association
*Muscatine—Public Health Nursing Association

KANSAS
Topeka—Metropolitan Life Insurance Nursing Service
Topeka—Shawnee County Health Department

LOUISIANA
Baton Rouge—East Baton Rouge Parish Health Unit

MAINE
Machias—District Health Unit No. 5—Maine State Bureau of Health

MASSACHUSETTS
*Northampton—Visiting Nurse Association

MICHIGAN
*Flint—Genesee County Health Department
*Mason—Ingham County Health Department

MINNESOTA
*Grand Rapids—Itasca County Nursing Service
*Minneapolis—Community Health Service
Naytahwaush—Mahnomen County Indian Service—Minnesota Department of Health
*Park Rapids—Hubbard County Nursing Service
Pipestone—County Nursing Service

(Continued on page A16)

*On Honor Roll five years or more.

NEWS AND VIEWS

Highlights on Wartime Nursing

NURSING COUNCIL LOOKS AHEAD

Wartime planning for postwar nursing, projected at least five years into the future, was given impetus in a recommendation calling for the appointment of a National Nursing Planning Committee, which received the approval of the Board of Directors of the National Nursing Council for War Service at its April meeting. The function of this Committee would be to formulate a five-year program coordinating the postwar activities of all member agencies of the Council. Membership would consist of the chairman of the postwar planning committees of the member agencies, the presidents of their boards, and the chief executives of their staffs. Member agencies will be asked to vote on this recommendation at their next meetings.

If approved, the new Committee will seek to obtain an overall picture of postwar nursing needs. It will review the plans already outlined by postwar committees of member agencies and draw up a coordinated program for nursing. Some of the steps under consideration will concern placement, postgraduate education, location of new schools, improvement of personnel practices, and methods of making nursing service available to all in need of it, whether at home or in institutions. Specific units of the program will then be allocated to the member agencies best geared to implement them, and joint projects which require united action by two or more agencies to the Council for the duration. The committee will review all requests for representation of nursing on postwar committees of other professional or lay groups, and assign representation from the Council, where indicated, or suggest representation from member agencies where their particular specialties are involved. It will be further empowered to set up a budget to finance the committee program, and to assist member agencies to secure necessary funds for their allocated projects.

CLASSIFICATION COMMITTEE

One hundred and forty-two nurses employed by national, federal and commercial agencies have been cleared by the National Classification Committee as available for military service, it was reported by Marion Sheahan, chairman, and their names sent to the American Red Cross as potential recruits for the armed forces. This group includes airline and railroad stewardesses, and nurses employed as agents for publishers of books on nursing topics.

CERTIFICATION FOR WAR FUND

The President's War Relief Control Board has certified the National Nursing Council for War Service for participation in the National War Fund. This, it is hoped, will assist nursing councils in securing funds for their wartime activities from state and local war chests. That several of them have already done so successfully seems evident from replies to a questionnaire sent out last month to state nursing councils.

While their basic financial support is provided by state nursing associations, aided by state boards of nurse examiners, alumnæ associations, district associations and individual nurse contributions, state war or defense councils maintained by official state appropriations have contributed substantially in a number of states. Contributions have also been obtained in several states from state war chests or war funds, supported by voluntary subscriptions, and from women's and civic clubs. A state board of health, a state hospital association, individual hospitals and schools of nursing, the Red Cross and large industries are also mentioned as contributors.

PAY RAISED

Executive Order 9439, setting $60 as the rate of pay for senior cadets in federal hospitals and agencies, was signed May 4 by President Roosevelt.

PROCUREMENT AND ASSIGNMENT

Ten thousand graduate nurses have been requested by the Army between now and July 1, 1945, according to a statement made on May 9 by Dr. Frank H. Lahey, chairman of the Directing Board of War Manpower Commission's Procurement and Assignment Service which is responsible for the equitable allocation of nurses between the armed forces and the civilian population.

"The Army would like at least five thousand nurses by December 31, 1944, and the balance no later than July 1, 1945," Dr. Lahey said, pointing out also that the Navy has a continued urgent need for at least 500 nurses a month until its full strength is achieved. In addition, both services will always require some replacements.

The Procurement and Assignment Service announcement has its origin in the recent increase by the Army of its ceiling for the Nurse Corps from 40,000 to 50,000. It is expected that the majority of nurses cleared for military service to meet the new Army ceiling will come from the ranks of new and recent graduates, so that an adequate number of older nurses can be kept on the home front.

"On the whole, the nursing profession has met its responsibilities magnificently," Chairman Frank H. Lahey said, calling attention to the fact that through the Procurement and Assignment Service 5,983 nurses had been assigned to duty with the Army or Navy from January through April of this year.

"We still have a long way to go however," he continued, "before the needs of the Armed Forces are met and in meeting those needs we must be sure that we are not neglecting the absolutely minimum requirements of the civilian population. The War Department has emphasized that they have no intention of depleting the nursing service in civilian hospitals. It stands to reason, however, that with over eleven million fighting men facing disease and death we must do our best to meet the military procurement objective."

Although all active graduate nurses in the United States have not yet been classified by Procurement and Assignment Service as to whether they are available for military service or essential to civilian care, reports from 32 states show that the nursing profession can still spare nurses for active duty with the Army or Navy. Fully 60,000 nurses have been classified in those states and those who have been declared available are expected to apply for a commission in the Army or Navy Nurse Corps.

Reports from the remaining states where classifications have not been completed are expected soon, Dr. Lahey said. He explained that the Procurement and Assignment Service which was established in 1941 to allocate physicians, dentists, veterinarians, and sanitary engineers, was not given responsibility for nurses until July 1943. A classification system for nurses, comparable to that established for physicians, was therefore established recently to anticipate military needs before they become acute.

Any statistical survey of the current nursing situation, according to Procurement and Assignment, runs immediately into the problem of continued change in numbers, as nurses shift positions. There is also the difficulty that the last nationwide census of nurses was a voluntary inventory conducted early in 1943 by the USPHS, to which 259,174 graduate nurses responded, with an estimated 20 to 30 percent failing to respond.

On the basis of the 1943 voluntary inventory, Procurement and Assignment estimated that on April 1, 1944, there were 245,045 graduate nurses in the United States actively engaged in professional work as civilians or in the services. Nursing requirements of that date were estimated at 345,000 graduate nurses.

According to the Public Health Service, there were 20,772 nurses engaged in the field of public health nursing on January 1, 1943, exclusive of those in industrial nursing. On April 1, 1944, there were 12,000 nurses engaged in the field of industrial nursing. According to the March, 1944, survey of the American Medical Association, there were 126,591 graduate nurses employed in 6,655 accredited hospitals in the United States.

SENIOR CADET ASSIGNMENTS

Recent reports received by the Division of Nurse Education, U. S. Public Health Service, indicate that comprehensive plans for the nationwide utilization of senior cadets are being made by health departments, health agencies and hospitals with no schools of nursing.

The Georgia Department of Public Health has arranged a program whereby senior cadets may receive supervised practice in public health nursing on the staffs of local health departments.

The departments have been approved for the assignment of senior cadets by the State Board of Nurse Examiners. Although cadet nurses will serve not less than three months, a six months' period is preferable.

There will be no formal classes for the senior cadet. Each student will have a staff nurse as her counselor. With the help of the supervisor of the agency, the counselor will plan the experience of the cadet nurse and teach her the necessary techniques and practices.

According to the program drawn up by the Georgia Department of Public Health, the cadet nurse will participate in maternal and child health conferences; venereal disease and tuberculosis clinics; immunization clinics and the school health program.

Also cooperating in the senior cadet program is the Southwestern Michigan Hospital Council, composed of representatives of 19 small (25 to 75 bed) hospitals. Working with the W. K. Kellogg Foundation five of these will be available to receive cadet nurses by June 1. Nursing experience as practiced in the small hospital will be offered in medical, surgical and obstetrical departments and actual field work with the county health departments, welfare agencies and other community resources associated with the participating hospitals.

Four senior cadets from the School of Nursing of Johns Hopkins Hospital, Baltimore, Maryland, will spend their senior cadet period with the Frontier Nursing Service, in Hyden, Kentucky, for special experience and training in rural district nursing. The Service will provide for the maintenance of cadets and their horses, riding uniforms and allowances.

INDUSTRIAL NURSES MEET

Three hundred seventy-five industrial nurses from 24 states met in St. Louis for their second annual convention on May 12-14, 1944. One day was given to joint meetings with the American Association of Industrial Physicians and Surgeons and the National Conference of Governmental Industrial Hygienists. Social gatherings were pleasantly interspersed with professional sessions.

Catherine Dempsey was re-elected president of the American Association of Industrial Nurses and other appointments were: Mrs. Gladys Dundore, executive secretary, and Mrs. Bethel McGrath, consultant.

Mary Adelaide Nutting Medal

MEDAL AWARD

The National League of Nursing Education announced on May 5 that the first issue of a medal in honor of Mary Adelaide Nutting, professor emeritus of Nursing Education at Teachers College, Columbia University, was presented to Miss Nutting by Stella Goostray, president of the League and chairman of the National Nursing Council for War Service, in a simple ceremony held at Miss Nutting's home on the campus.

In presenting the medal to Miss Nutting, Miss Goostray spoke as follows: "In commemoration of the Fiftieth Anniversary of the National League of Nursing Education and as a symbol of the honor, affection and gratitude which your colleagues have for you, there was created the Mary Adelaide Nutting Award to be conferred for leadership in nursing education. It is my high privilege today, as president of the League, to present the first medal to you. It is largely to your leadership we are indebted for the progress that nursing education has made in this country. With your constant emphasis on sound educational, social, and economic principles for schools of nursing, we have gone forward towards a worthy preparation for the practice of nursing. We are confident that a medal bearing your name will be an inspiration in the years to come for others to continue the high quality of your leadership."

The original plaque from which the medal was cast was designed by Malvina Hoffman.

NURSE'S AIDES WITH PAY

New policies on employment of nurse's aides with pay, in civilian and army hospitals, are explained by the National Nursing Council in a letter to state and local councils, May 9.

In order to increase the hours of service from nurse's aides, consideration has been given to the question of granting temporary leave of absence from the Volunteer Nurse's Aide Corps for aides who, by accepting some compensation, were able to give full-time service. A special committee was set up, with William Carl Hunt as chairman, to consider this and other questions. Following recommendations of this committee, the Central Committee of the Red Cross issued the following statement:

"If a volunteer nurse's aide accepts a position as a paid nurse's aide, she shall, during the period of such compensated service, be given temporary leave of absence from the Volunteer Nurse's Aide Corps; during such period she shall not wear the uniform or insignia of the Volunteer Nurse's Aide Corps."

The Red Cross, in response to a request from Gen. Norman T. Kirk, Surgeon General of the United States Army, has also approved employment of nurse's aides by the Army to assist nurses and help overcome the manpower shortage. They will be classified as civilian employees, responsible directly to the designated representatives of the Army Service Commands employing them. The aides are being given a civil service classification, with salaries set at $1,320 a year which, with deductions for quarters, board, civil service retirement and withholding tax, works out at approximately $75 a month.

Only women with Red Cross Volunteer Nurse's Aide certificates, who have given 150 hours of volunteer service on hospital wards, are eligible for these positions.

From Far and Near

• The deficiency bill signed by the President April 1 includes an item of $115,000,000 for community facilities (Lanham Act) under the Federal Works Agency. The much disputed day-care program for children of working mothers, among other community facility projects, can now go ahead.

• Helen G. Schwarz, former dean of the College of Nursing and Health at the University of Cincinnati, has been appointed assistant director in charge of the eastern area according to an announcement from Lucile Petry, director, Division of Nurse Education, U. S. Public Health Service. Mrs. Marguerite Heimes and Mrs. Mary B. Lowery have been appointed as nurse education consultants on the Division staff.

• Two former public health nurses, 1st Lt. Margaret M. Cameron of New York City and 2nd Lt. Catherine Gray, Schuylkill Haven, Pennsylvania, have been assigned to the administrative staff of the ARC in the Afro-Italian theater. The two army nurses will supervise the health of 850 Red Cross workers in that region, many of whom are billeted in apartments or with private families and are eating at civilian-operated messes. Bedside nursing is required when the Red Cross personnel is not ill enough to require hospital space; also, liaison with the Army is necessary when they are sent to Army hospitals. Other duties of these nurses include inspection of Red Cross clubs, which offer food and showers to American soldiers, to meet Army hygienic standards.

• The appointment of Dr. Wilbur A. Sawyer of New York as director of the Health Division of the United Nations Relief and Rehabilitation Administration has been announced. He will be responsible for planning and directing health and medical activities.

• Dr. Paul C. Barton has been appointed executive officer by the Directing Board, Procurement and Assignment Service, War Manpower Commission. He succeeds Commander M. E. Lapham who has been ordered to active duty at the Naval Hospital, San Diego, California.

• Announcement has been made that the School of Nursing and Nursing Service of the Johns Hopkins Hospital will, beginning in October 1944, admit only those applicants who have a baccalaureate degree from a college or university, accredited by a national or regional association

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